

**CITY OF BALTIMORE**

**HEALTH DEPT.**

**BUREAU OF**

**VITAL STATISTICS**



**DEATHS**

**BEGINNING 1910**



CITY HALL  
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

## DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT  
THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE  
DEPARTMENT OF Health BUREAU OF Vital  
Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS  
AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COM-  
PLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PRO-  
VIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION  
NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN  
ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR  
ON JUNE 4, 1954.

## REQUEST FOR RETENTION PERIOD

To: Records Management Officer,  
Room 408, City Hall, Baltimore, 2, Md.

Authorization No.

345

Department:

Health

Bureau:

Vital Statistics

## Record Identification

1. TITLE: <b>Certificate of Death</b>		2. Form No. if available		3. Type—(cards, paper, etc.) <b>Bound Book</b>	
4. Dates	5. Volume accumulated yearly	6. Size of Record <b>Misc.</b>	7. Number of copies made <b>One (1)</b>		
8. Authorization Requested (check only one (1) of the squares below)					
A. Establish retention period for <input type="checkbox"/> records which are accumu- lating daily.		B. Dispose of present accumu- lation, no additional accumu- lation anticipated.		C. Microfilm and destroy orig- inals. <input type="checkbox"/>	
				D. Microfilm and retain origi- nals for length of time in- dicated below. <input checked="" type="checkbox"/>	
9. Recommended Retention Period			10. Equipment and space freed.		11. In your opinion does this record have any his- torical significance?
a. In Dept. <b>12 yrs.</b>			b. In Storage Center <b>Micro. Perm.</b>		c. Total <b>12 yrs. and Micro. Perm.</b>
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)					

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.  
Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval

*Robert E. Fairley, M.D.*  
Title: Commissioner of Health

*3/28/63*  
Date

## Recommendation of Records Management Officer

13. Recommended Retention Period			14. Disposal Method		
a. In Dept. <b>12 yrs.</b>	b. In Storage Center <b>Microfilm Permanent</b>	c. Total <b>12 yrs. and Microfilm Permanent</b>	A. To be sold as scrap or waste paper <input type="checkbox"/>	B. To be Burned or shredded <input checked="" type="checkbox"/>	C. Historical, (to be transferred to Dept. of Legislative Reference.) <input type="checkbox"/>
REMARKS: <i>2 negative Rolls</i>					
			<p><i>C. P. Force</i> Records Management Officer</p> <p><i>3/28/63</i> Date</p>		

## APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER  
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

**FILED ON FILM**

**IN**

**NUMERICAL ORDER**

# **NOTICE**

The succeeding documents  
were received in the same  
condition and microfilmed  
as shown.

Every effort was made to  
assure legibility and com-  
pleteness.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30846

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 Byrd St.

ST. 24-34 WARD)

## 2-FULL NAME Marie Lacher

(a) RESIDENCE No. 1836 Byrd St

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

a If married, widowed, or divorced

HUSBAND of

(or) WIFE of : Joseph H. Lacher

DATE OF BIRTH (month, day, and year) Aug. 1 1879

AGE Years Months Days If LESS than 1 day, hrs. or min. 48 6 19

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employee)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Adam Metzler

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaret Zang

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

Informant Mr. Metzler

(Address)

1836 Byrd St

Filed

19

G. HAMPSON JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

46 DATE OF DEATH (month, day, and year) Feb 20 19 28

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 19 27, to Feb 20, 19 28 that I last saw him alive on Feb 20, 19 28

and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. H. Campbell, M.D.

2/23, 1928 (Address) 1644 Hanover St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Cemetery

DATE OF BURIAL

24 1928

ADDRESS

130 E. Fort

20 UNDERTAKER

L. H. McLaughlin



## HEALTH DEPARTMENT—CITY OF BALTIMORE

30847

## CERTIFICATE OF DEATH.

113  
E 30847  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 702 Warner St. 22-30 Ward)

## 2-FULL NAME

James Crawford Jr

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 702 Warner St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/24/27

7 AGE Years 28 Months 3 Days 21 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

## 10 NAME OF FATHER

Jas. Crawford

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Texas

## 12 MAIDEN NAME OF MOTHER

Flossie Cooper

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S. C.

4 Informant (Address) 702 Warner St.

B 23 1928 HAMILTON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/28 19

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1928, to Feb. 21, 1928, that I last saw him alive on Feb. 21, 1928, and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH\* was as follows:

Gastro-enteritis (duration) 3 yrs. mos. 2 ds.

CONTRIBUTORY Gastro-enteritis (Secondary) (duration) 6 yrs. mos. 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) W. H. Thompson, M. D.

, 19 (Address) 1512 N. Lafayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt. Calvary Feb 23 1928

UNDERTAKER

ADDRESS

R. L. Parker 829 Beaman

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30848

## CERTIFICATE OF DEATH.

41 E 30848

## 1-PLACE OF DEATH

## REGISTERED NO.

CITY OF BALTIMORE: (No. 1015 N. Carrollton Ave. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Demines

(a) RESIDENCE NO. 1015 N. Carrollton Ave. ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Math Demines

DATE OF BIRTH (month, day, and year) Aug. 20th, 1878

AGE Years Months Days If LESS than 1 day, hrs. or min.

49

5

18

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Singer's Wash

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Amos Demines

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Lucy White

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ga

Informant (Address)

Math Demines 1015 N. Carrollton Ave.

Filed

23 1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18th 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 18th, 1928, to Feb 5th, 1928, that I last saw him alive on Feb 17th, 1928, and that death occurred, on the date stated above, at (304) m.

The CAUSE OF DEATH\* was as follows:

Septicemia from infected lute

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

Chronic

(Signed)

R. H. Ellis, M. D.

(Address)

524 Wood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt Auburn Cemetery

20 UNDERTAKER

Thomas G. Nelson

DATE OF BURIAL

2/22 1928

ADDRESS

1303 Priestman St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30849

## CERTIFICATE OF DEATH.

121 30849

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1377 Woodyear*ST. *15-23* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Joshua Dennis*(a) RESIDENCE No. *1377 Woodyear*

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *10* yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *colored* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

If married, widowed, or divorced HUSBAND of or WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *Jan 22, 1900*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*28**0**29*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) (State or country) *A. A. Co md.*10 NAME OF FATHER *Edward Dennis*

11 BIRTHPLACE OF FATHER: (city or town)

(State or country) *A. A. Co md.*12 MAIDEN NAME OF MOTHER *Jennie Sorrell*

13 BIRTHPLACE OF MOTHER: (city or town)

(State or country) *A. A. Co md.*Informant *Organ Dennis*(Address) *1377 Woodyear st*

B 23 1928

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 21 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Jan. 21 - 1928* to *Feb. 21 1928* that I last saw him alive on *Feb 21 - 1928*and that death occurred, on the date stated above, at *6:30 P. m.*

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) *Chronic Interstitial Nephritis*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Positive*(Signed) *W. H. K. M. D.* M. D.1-21-1928 (Address) *708 E. 25*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Shady side. md*

20 UNDERTAKER

*Thomas E. Nelson*

DATE OF BURIAL

*Feb 22 1928*

ADDRESS

*1303 Pricestman st*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

30850

## CERTIFICATE OF DEATH.

12 E 30850

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 N Smallwood ST., 15-68 WARD)

2. FULL NAME Nathan London

(a) RESIDENCE NO. 1705 N Smallwood ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds.

(If non-resident give city or town and State)

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Elta London

DATE OF BIRTH (month, day, and year)

AGE 58. Year 18 Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant

(Address) 1705 N Smallwood ST

Filed

23 1928 H. JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23 1928

17

HEREBY CERTIFY, That I attended deceased from Feb 16, 1928, to Feb 23, 1928.

that I last saw him alive on Feb 23, 1928, and that death occurred, on the date stated above, at 5-9 m.

The CAUSE OF DEATH\* was as follows:

Uremic Comma

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds. Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

2/23/25 (Address) 1676 N Kentland St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Hebrew Roadside Jack Lewis 1429 E. Pratt St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30851

E 30851

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 St. Appellton ST. 15-21 WARD)

## 2-FULL NAME

Louis Scherr

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1601 St Appellton St

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 42 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

If married, widowed, or divorced

HUSBAND of  
or) WIFE of

Minnie Scherr

DATE OF BIRTH (month, day, and year)

AGE

71

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Russia

10 NAME OF FATHER

Anton

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Anton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

Informant

(Address)

Minnie Scherr

1601 St Appellton St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/23

1928

17

I HEREBY CERTIFY, That I attended deceased from

2/2/28

, 19

2/23/28

, 19

that I last saw him alive on

2/23/28

, 19

and that death occurred, on the date stated above, at

29

m.

The CAUSE OF DEATH\* was as follows:

Leukemia

(duration)

yrs.

mos.

10 ds.

CONTRIBUTORY  
(Secondary)

Benign Prostatic Hypertrophy

(duration)

10 yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Rectal Examination

(Signed)

Charles D. Lewis

M. D.

, 19

(Address)

Medical Arts Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MORTAL

Hebrew Hesperian Bur

DATE OF BURIAL

2/23

1928

20 UNDERTAKER

Jack Lewis 1439 E. 1st St.

FEB 23 1928 HENRY JONES, M. Registrar

30852

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *28* ST. *28th* WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

*Lifetime*

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

*Life*

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*Aug - 1884*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*73**74**June*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*David Edan*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Frankfurt Germany*

12 MAIDEN NAME OF MOTHER

*Lena Weil*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baranov*

Informant (Address)

*Records of Mt Hope Re mal Baltimore*

8-23-1928

*HAUDON JONES, M. Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 22nd 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Aug. 1884*, to *Feb 22nd 1928*.that I last saw him alive on *Feb 21st 1928*.and that death occurred, on the date stated above, at *10:55 A.M.*

The CAUSE OF DEATH\* was as follows:

*Graugue of foot Left foot arterio-sclerosis*(duration) *1* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

*Senile Dementia*(duration) *14* yrs. *0* mos. *0* ds.18 Where was disease contracted if not at place of death? *Baltimore Md*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery*, M. D.7th, 1928 (Address) *Mt Hope Re mal*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Beth Hebrew Cons**2/24/28*

20 UNDERTAKER

*David Soudaheim*

ADDRESS

*118-20th. Md. Royal Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30853

## CERTIFICATE OF DEATH.

31 E 30853

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *106 Wilhelm Ave* 5-17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George Cox*(a) RESIDENCE NO. *106 Wilhelm Ave*

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *4* yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*widowed*

(a) If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Late Margaret Cox*

DATE OF BIRTH (month, day, and year)

*Aug 31 1870*

AGE

*57*

Years

Months

*5*

Day

*20*If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Firman* *at*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Stationary*

(c) Name of employer

*Balto*BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

*William Cox*

11 BIRTHPLACE OF FATHER (city or town)

*md.*

(State or country)

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER (city or town)

*unknown*

(State or country)

Informant  
(Address)*William Connor*  
*106 Wilhelm Ave*

Filed

*3 1928*

19

*W. H. Jones, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 21, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*7/10, 1928*

to

*2/21**1928*

that I last saw him alive on

*2/10**1928*

and that death occurred, on the date stated above, at

*5:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pul Phthisis**with acute Pyemia*

(duration)

mos

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

*usual*

(Signed)

*Benjamin P. Long*

M. D.

*7/2, 1928* (Address)*910 N. Lombard*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Jessup's Balto Co.*

UNDERTAKER

*Chenoweth*

DATE OF BURIAL

*Feb 24, 1928*

ADDRESS

*3615 Chestnut Ave*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30854

## CERTIFICATE OF DEATH.

90 E 30854  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2014 88-39 St. 13-57 Ward)2-FULL NAME Elizabeth H. Rooney(a) RESIDENCE NO. 2014 88-39-15 St. 13 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race white5 Single, Married, Widowed,  
or Divorced, (write the word) married6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of James Rooney6 DATE OF BIRTH (month, day, and year) Feb 22 1885

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.421128

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Housewife(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. Md.

(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown14 Informant  
(Address) James Rooney  
2014 W 39th St

15 Filled

C. HAMPTON JONES, M.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an Inquest, autopsy or inquiry,  
thereon and from the evidence obtained by said Inquest, au-  
topsy or inquiry, find that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH was as follows:

Coronary Disease  
of Heart

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)(Signed) Robert M. D.(Address) 9682 Robert M.  
St.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place  
of death.....yrs.....mos.....ds. In the  
State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Date of Burial

20 UNDERTAKER

St. Marys Hampden  
Chenoweth  
Feb 23 1928  
3615 Chestnut

E 30855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66  
E 30855  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: *Amor Memorial Hospital* St. *13* Ward

2-FULL NAME *Albert E. Febbeck*

(a) RESIDENCE NO. *3729 Falls Road* St. *3* Ward *3*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 Color or Race *white* 5 Single, Married, Widowed, or Divorced (write the word) *single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE *50* Years Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Carpenter*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) *England*  
(State or country)

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) *Unknown*  
(State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Unknown*  
(State or country)

14 Informant *Alice E. Spay*  
(Address) *3729 Falls Road*

15 Filed *23 1928* *HAMILTON JONES, M.* Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/23 1928*

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Acc to Alce Holan*

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) *Dr. J. M. D.* (Coroner)

*20, 1928* (Address) *3632 Roland*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. ....mos. ....ds. In the .....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial *Feb 23 1928*

*St. Marys Hospital*  
20 UNDERTAKER *Chenobethor* ADDRESS *3615 B Street*

E 30856

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 30856

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1537 N. E. Street 8-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 1537 N. E. Street

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth 18 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 12/1873

7 AGE

Years

Months

Days

LESS than 1 day...hrs. or min..

52 4 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Teacher of

(b) General nature of industry, business, or establishment in which employed (or employer)

Manager of

(c) Name of employer

Own Self.

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md

10 NAME OF FATHER

Sampson Hartz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Elmer Jones  
1537 N. E. Street

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 4 1928

17

I HEREBY CERTIFY, That I attended deceased from

Nov 27<sup>th</sup> 1927, to Dec (3/4/) 1928that I last saw him alive on Jan 6<sup>th</sup> 1928and that death occurred, on the date stated above, at 8 25 a m

The CAUSE OF DEATH\* was as follows:

Infantile Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Emaciated

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) A. McArthur M. D.1928 (Address) 1114 N. E. Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

1604 Redman St Feb 24<sup>th</sup> 28

UNDERTAKER

ADDRESS

William Cook & Co

FEB 23 1928 HANCOCK JONES M

Per



B 30857

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Square Hospital*CITY OF BALTIMORE: (No. *100 Calhoun*ST. *26*

WARD)

2-FULL NAME *Lillian Neimeyer*(a) RESIDENCE NO. *409 S. East Ave.*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred *30*

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

138  
E 30857  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Married*5a If married, widowed, or divorced  
HUSBAND or  
(or) WIFE of*John Neimeyer*6 DATE OF BIRTH (month, day, and year) *April 10/1897*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*30**10**13*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Ch. Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*

10 NAME OF FATHER

*Lily L. Lowman*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore Md*

12 MAIDEN NAME OF MOTHER

*Mary Bell*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore Md*Informant  
(Address)*John H. Neimeyer  
409 South East Avenue*

23 1928

C. HANCOCK JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-23 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 8 1928 to Feb 23 1928.*that I last saw her alive on *Feb 23 1928.*and that death occurred, on the date stated above, at *1 15 A.m.*

The CAUSE OF DEATH\* was as follows:

*Salpingitis*CONTRIBUTORY  
(Secondary)*Septicemia*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?*Unknown*

Did an operation precede death?

*Yes Date of Feb 27, 1928*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Lat. & Physical Exam*

(Signed)

*Louis H. Tollin* M. D.

, 19

(Address)

*Franklin Square Hosp.  
Baltimore Md*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Oak Lawn Cemetery*

UNDERTAKER

*William Cook*

DATE OF BURIAL

*2/27 1928*

ADDRESS

*507 E. North*

E 30858

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101 E 30858

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17177 Baltimore ST. 14-28 WARD)

## 2-FULL NAME Elma E Chalk

(a) RESIDENCE NO. 17177 Baltimore ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Chalk

DATE OF BIRTH (month, day, and year) Sep 14, 1884

AGE

Years 43

Months 5

Days 8

If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant (Address) Charles Chalk 17177 Baltimore St

Filed 23 1928

HAMPDEN JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Feb 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 22nd, 1928, to Feb 22nd, 1928, that I last saw her alive on Feb 22nd, 1928, and that death occurred, on the date stated above, at 4:55 m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) C. H. Hiden, M. D.

19 (Address) 867 N 36 St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore

DATE OF BURIAL

2/25 1928

ADDRESS

503 E Main

20 UNDERTAKER

W. H. Cook

E 30859

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30859

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 N. ~~Calhoun~~ St. ST. 14-27 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Matilda V. Holly

## (a) RESIDENCE NO.

309 N. ~~Calhoun~~ St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

Negro

wid.

a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Jas. R. Holly

DATE OF BIRTH (month, day, and year)

1859 Date unknown

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

68

Unkn

10

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town (State or country))

Northumberland Co. Va.

10 NAME OF FATHER Robert Newlett

11 BIRTHPLACE OF FATHER (city or town (State or country))

Va.

12 MAIDEN NAME OF MOTHER Mary Keys

13 BIRTHPLACE OF MOTHER (city or town (State or country))

Va.

Informant (Address)

J. Holly (Son)

1609 Mosher St

Filed

1925

C. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan. 31st, 1928, to Feb. 21st, 1928,

that I last saw her alive on Feb. 20th, 1928.

and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH\* was as follows:

Ch. Int. Nephritis and Mitral Ins.

(duration) yrs. 8 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted At place of death if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Ex. Post. and Urin.

What test confirmed diagnosis? (Signed) after Jackson, M. D.

(Address) 1631 W. Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

ADDRESS

E 30860

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30860

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401.7 Colmar ST. 12-49 WARD)2-FULL NAME John Wesley Berner(a) RESIDENCE No. 3401.7 Colmar ST. 12-49 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 6 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Singlea If married, widowed, or divorced HUSBAND of (or) WIFE of ✓DATE OF BIRTH (month, day, and year) March 15 - 1928

AGE

Years 2Months 11Days 6

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md  
(State or country)10 NAME OF FATHER John Berner11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Helen Z. Schliesser13 BIRTHPLACE OF MOTHER (city or town) Bohemia  
(State or country)Informant Mr. John Berner  
(Address) 3401.7 Colmar St. B.File 223 1928Per Kell

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 11, 1928, to Feb 21, 1928, that I last saw him alive on Feb 21, 1928, and that death occurred, on the date stated above, at 10.15 P. m. The CAUSE OF DEATH\* was as follows:Influenza(duration) yrs. mos. 10 ds.CONTRIBUTORY Broncho Pneumonia  
(Secondary)(duration) yrs. mos. 6 ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical symptoms(Signed) Wm. Pearce, M. D.2-22, 1928 (Address) St Paul & Preston St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Ouraine CemDATE OF BURIAL Feb 28 1928UNDERTAKER H. J. Jackson, Jr.ADDRESS 7-1a

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30861

## CERTIFICATE OF DEATH.

44 E 30861

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bald City Hospital 9-18 ST. 9-18 WARD)

## 2-FULL NAME

(a) RESIDENCE No. 574 N. Bay ST. 9-18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofRebecca ShearerDATE OF BIRTH (month, day, and year) Dec 29-1861AGE 66 Years 1 Months 23 Days 2 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

JAMES CON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21-1928

17

I HEREBY CERTIFY, That I attended deceased from 11-18-1927, to 2-21-1928 that I last saw him alive on 2-21-1928 and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of StomachCONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Jones, M.D., 19 (Address) Bald City Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



HEALTH DEPARTMENT—CITY OF BALTIMORE

30862

## CERTIFICATE OF DEATH.

31 E 30862

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 912 Warner St. St. 21-21 Ward)

2-FULL NAME Mary Turner Harris. (C)

(a) RESIDENCE NO. 912 Warner St. St.        Ward         
(Usual place of abode)

(Usual place of abode) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
Length of residence in city or town where death occurred 5 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Colored	Married

Is If married, ~~Wife of~~ ~~XXXXXX~~  
~~XXXXXXXXXX~~  
 (or) WIFE of Joseph Harris. (C)

6 DATE OF BIRTH (month, day, and year) February 14, 1904.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	24	0	6	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....None.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) .....  
(State or country) ..... Virginia.

10 NAME OF FATHER Simon Sotrell.(C)

II BIRTHPLACE OF FATHER (city or town).....  
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary F. Cook. ) C)

18 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) Virginia

14 Informant Mary Correll. (mother.  
(Address) 912 Warner St.

Filed **23** 1928. **C. HAMPSHIRE JONES, M**  
 Registrar

**CORONER'S CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) February 20, 1928. 1928

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death

The CAUSE OF DEATH\* was as follows:

## Pulmonary Tuberculosis.

(duration) .....yrs. ....mos. ....da

**CONTRIBUTORY**  
(Secondary)

(duration) 8 yrs. mos. ds.  
(Signed) H. H. Linnhardt, M. D.  
(Coroner)

2/22<sup>19</sup>23 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR Date of Burial

723 1927  
 DERTAKER

DEBTAKER *James H. Haskins* ADDRESS *M. B. H.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30863

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Woodland a ST., 15-61 WARD)

## 2-FULL NAME

Emma Jackson Dembracco

## (a) RESIDENCE NO.

3704 Woodland a ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

F.

W

Widow

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Nathan Dembracco

DATE OF BIRTH (month, day, and year)

May 1<sup>st</sup> 1845

AGE

83 Years

Months

9

Days

21

If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Phila. Pa.

10 NAME OF FATHER

Wesley Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Emma J. Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant

(Address)

Clarence A. Dembracco

2716 Woodland a

Filed

19

HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/28. 19

17

I HEREBY CERTIFY, That I attended deceased from

May, 1927, to Feb 21<sup>st</sup>, 1928.that I last saw him alive on Feb 21<sup>st</sup>, 1928.

and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Leukemia

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical

(Signed) John D. Scriff, M. D.

19 (Address) 1843 W. Balto. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Woodlawn Cem

20 UNDERTAKER

George J. Smith

DATE OF BURIAL

Feb 23 1928

ADDRESS

132 Hollins

E 30864

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.

WARD)

## 2-FULL NAME

Theodore Nolley

(a) RESIDENCE No.

2021 Madison Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

black

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

3-21-27

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

11

9

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

George Nolley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Maggie McCullough

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

Informant (Address)

Records

Filed

C. HAYSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 7, 1928, to Feb 21, 1928

that I last saw him alive on Feb 21, 1928,

and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH\* was as follows:

lobar pneumonia, primary, right and left lungs. (Chronic in left lung).

(duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary) Otitis media, bilateral

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) J. J. Bennett, M. D.

Feb. 21, 1928 (Address) Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Auburn

UNDERTAKER

Mrs. R. Q. Elliott

DATE OF BURIAL

Feb. 23, 1928

ADDRESS

1115

Ashland



E 30865

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30865

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3910 Ferwood ST., 10-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Charles H. H. Blissham(a) RESIDENCE NO. 3910 Ferwood ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE W5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25-1900

7 AGE

Years 27Months 9Days 26

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Club

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. ClubBIRTHPLACE (city or town) (State or country) Balto. Md.10 NAME OF FATHER James H. Blissham11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.12 MAIDEN NAME OF MOTHER Charlotte Blissham13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.Informant (Address) 3910 Ferwood St., Baltimore, Md.B File 23 1928

HARRISON JONES, M. D., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1928

17

I HEREBY CERTIFY, That I attended deceased from 6/26, 1926, to 2/20, 1928, that I last saw him alive on 2/20, 1928, at 5:30 p. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) yrs. 20 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Jones

M. D.

(Address) 633-5-3rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 3000J. H. Jones

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30866

## CERTIFICATE OF DEATH.

129 E 30866

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 E. Jefferson ST., 6-10 WARD)

## 2-FULL NAME

(a) RESIDENCE No. 2403 E. Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of May A. Lewis

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE 66 Years Month Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Jno. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Leo Lewis

(Address) 2403 Jefferson St.

Filed

1928 HAMPSHIRE JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 22 1928

17 I HEREBY CERTIFY, That I attended deceased from February 18, 1928, to February 22, 1928.

that I last saw him alive on February 22, 1928.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic Diffuse Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayer, M. D.

7422, 1928 (Address) 200 S. E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Buried at Federal Hill

2/24/1928

20 UNDERTAKER

ADDRESS 3000

J. G. Moran

E. Betts

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30867

## CERTIFICATE OF DEATH.

90 E 30867

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 104 W. Ostend St. St. 23-31 Ward)

2-FULL NAME Albert O. Schmidt.

(a) RESIDENCE NO. 104 W. Ostend St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 3 mos. 8 ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, ~~WIFE~~ HUSBAND of Catherine Schmidt.

6 DATE OF BIRTH (month, day, and year) November 13, 1871

7 AGE Years 56 Months 3 Days 8 IF LESS than 1 day...hrs. or...min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar manufacturer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

10 NAME OF FATHER Carl Schmidt.

11 BIRTHPLACE OF FATHER (city or town) Germany.

12 MAIDEN NAME OF MOTHER Catherine Weidman.

13 BIRTHPLACE OF MOTHER (city or town) Germany.

14 Informant Catherine Schmidt. (wife) (Address) 104 W. Ostend St.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 February 21, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Embolism.  
Myocarditis, Endocarditis.

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. M. Reinhardt M. D. (Coroner)

2/21 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery.

20 UNDERTAKER

J. A. Kravuse.

Date of Burial

Feb. 24 1928

ADDRESS

105 Hanover St

23 1928 C. HAMPSON JONES, M.

Per R. R. Y. Registrar

*Louisa M Zark*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30868

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1521 Homestead* ST. *9-46* WARD)

## 2-FULL NAME

(a) RESIDENCE No. *1521 Homestead* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *64* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *husb* *never married*6 DATE OF BIRTH (month, day, and year) *unknown*7 AGE *64* Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *house maid*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *not employed at death*9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)10 NAME OF FATHER *John Zark*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Helwig*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)Informant *Mrs Annie Kubo* (Address) *1521 Homestead St*Filed *1928* C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 21 1928*

17

I HEREBY CERTIFY That I attended deceased from *July 1928* to *July 21 1928* that I last saw her alive on *July 21 1928* and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH\* was as follows:

*Bright's disease*(duration) *one* yrs. mos. ds.CONTRIBUTORY (Secondary) *Bright's disease*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *yes*

Did an operation precede death? Date of

Was there an autopsy? *no*What test confirmed diagnosis? *Bedouin*(Signed) *James M. Hethcote* M. D.19 (Address) *1683 Gordon St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Baltimore Cemetery* *Feb 25 1928*  
*Johanna Charles 1007 Arguilla St*





E 30870

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30870

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 8 WARD)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2. FULL NAME Dora Strick(a) RESIDENCE No. 1801 W. Washington

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds.

WARD \_\_\_\_\_

(If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) Oct 25 - 1838AGE Years 92 Months 3 Days 28 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Isidor11 BIRTHPLACE OF FATHER (city or town) (State or country) Isidor12 MAIDEN NAME OF MOTHER Isidor13 BIRTHPLACE OF MOTHER (city or town) (State or country) IsidorInformant (Address) C. THOMPSON JONES, M. D.

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/192817 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1928, to Dec. 21, 1928that I last saw him alive on Dec. 21, 1928 and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH\* was as follows:

Brain aneurysm(duration) yrs. mos. ds. 4CONTRIBUTORY (Secondary) hypertension

18 Where was disease contracted if not at place of death? yrs. mos. ds.

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? General + Spleen(Signed) C. Thompson Jones M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cemetery Feb 24 1928

20 UNDERTAKER

ADDRESS 1203Henry Lutz113 Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

30871

## CERTIFICATE OF DEATH.

52 E 30871

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1111 N Bond* ST. *7-13* WARD)2-FULL NAME *Joseph (Breunig) Breunig*(a) RESIDENCE (No. *1111 N Bond* ST. WARD)

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *45* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mathurine Breunig*6 DATE OF BIRTH (month, day, and year) *Nov 12 1859*7 AGE *68* Years Months *3* Days *10* If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *G* (State or country) *Germany*10 NAME OF FATHER *Joseph Breunig*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*Informant *Mrs Mathurine Breunig* (Address) *1111 N Bond St*Filed *1928* C. HAMPSON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-22 1928*17 I HEREBY CERTIFY, That I attended deceased from *2-1*, 19*26*, to *2/22*, 19*28*.that I last saw him alive on *2/22*, 19*28*.and that death occurred, on the date stated above, at *9 A.* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction*(duration) yrs. mos. *2* ds.CONTRIBUTORY (Secondary) *Multiple Hypertensive arthritis* (duration) *7* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis *Clinical signs*(Signed) *Sam Miller*, M. D.Jr., 19*28* (Address) *1500 N Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*St Matthews Cemetery* DATE OF BURIAL *Feb 24 1928*20 UNDERTAKER *Henry Lutz* ADDRESS *1203**N Broadway*

30872

## HEALTH DEPARTMENT—CITY OF BALTIMORE

30872

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 18-76)

WARD)

2-FULL NAME

Baby Girl Rose

(a) RESIDENCE NO.

869 W. Fayette St

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

white female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

infant

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Feb 8, 1928

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Balt Md

10 NAME OF FATHER

Rufus Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Mary Rebecca

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

Informant (Address)

University Hospital

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/19 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 9, 1928, to Feb 19, 1928,

that I last saw her alive on Feb 19, 1928,

and that death occurred, on the date stated above, at 7:25 a.m.

The CAUSE OF DEATH\* was as follows:

Congenital Heart Disease  
Atelektasis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Brando Muennerich

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Clinical

(Signed)

A. H. Schubert, M. D.

, 19

(Address)

University Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

FEB 23 1928

1928

C. HAMPSON JONES, M. D.  
Registrar



Person  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30873

## CERTIFICATE OF DEATH

E 30873

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 101-001)2-FULL NAME Paul Person(a) RESIDENCE NO. 903 Plum Alley

(Usual place of abode)

St. Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 12, 1900

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER Frank Person

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Pauline Gray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 Filed

1928

C. HAMPSON JONES, M. D.

Per

2203

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

2/14, 1928, to 2/20, 1928that I last saw him alive on 2/20, 1928and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. mon. 10 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mon. 8 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis

(Signed) Geo. W. Thompson M. D.

19

(Address)

\*State the Disease Causing Death, or deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER Wm. H. Jones

Commissioner Health

Wm. H. Jones

FEB 28 1928

916 Penn. Ave.

E 30874

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30874

1-PLACE OF DEATH

113 South Fifth Street Brooklyn, Md

Registered No. ....

City of BALTIMORE: (No. ....

St. 25-75 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henry Faber

(a) Residence No. ....

(Usual place of abode)

St. .... Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

79 yrs. 10 mos. 5 ds.

Now long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Single,

Married,

Widowed,

or Divorced,

(Write the word)

Married

5a-If married, widowed, or divorced

HUSBAND of (or) WIFE of

Louisa Faber

6-DATE OF BIRTH (month, day and year)

April 17<sup>th</sup> 1848

7-AGE

If LESS than 1 day

79 yrs. 10 mos. 5 ds.

hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town)

(State or Country)

Baltimore, Md

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

Germany

4- (Informant)

Louisa Faber

(Address)

113 S. Fifth St Brooklyn

Filed

1928

C. HAMPSON JONES, M. D., Registrar.

## CERTIFICATE OF DEATH.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

Feb 22-1928

17- I HEREBY CERTIFY, That I attended deceased from

Feb 19 1928 to Feb 22 1928

that I last saw him alive on Feb 22 1928

and that death occurred, on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia,

CONTRIBUTORY (Secondary)

Acute Dilatation of Heart

18-Where was disease contracted If not at place of death?

Did an operation precede death?

NO

Was there an autopsy?

NO

What test confirmed diagnosis?

Physical Findings

(Signed)

Allen W. Kelly

M. D.

19

(Address)

1412 Light St.

\*State the Disease Causing Death, or in Deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Crem

Feb 25, 1928

20-UNDERTAKER

ADDRESS

E. Schuman Son

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30875

## CERTIFICATE OF DEATH.

188-002 E 30875

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

N. Balto. Genl Hosp 46  
St., Ward

## 2-FULL NAME

Annie E. Watson

## (a) RESIDENCE NO.

2100 Homewood Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank C. Watson

6 DATE OF BIRTH (month, day, and year) ? ? 1858

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. About 70

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. House

(b) General nature of industry, business, or establishment in which employed (or employer). 17016

(c) Name of employer

9 BIRTHPLACE (city or town) Shrewsbury, (State or country) Maine

## 10 NAME OF FATHER

Goring

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Mrs Mary E. Watson 2100 Homewood Ave

15 Filed 1928 16 C. HAMPSON JONES, M. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

Person and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

St Car Accident Fracture of Skull (duration) 2 hrs

CONTRIBUTORY (Secondary) 17016 (duration) 2 hrs (Signed) J. C. Bladen M. D. (Address) 143 16 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION, OR REMOVAL

Shrewsbury Maine Date of Burial July 28

## 20 UNDERTAKER

J. E. Anderson 143 16 Bway

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 30876

E 30876

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 Bruce)ST. 17 WARD 16

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME George R. Handy(a) RESIDENCE NO. 523 Bruce

(Usual place of abode)

ST. 17 WARD 16

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Handy6 DATE OF BIRTH (month, day, and year) Feb 22 18987 AGE Years 78 Months 0 Days 0 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER George R. Handy11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Elizabeth13 BIRTHPLACE OF MOTHER (city or town) (State or country) MarylandInformant (Address) John E. Jones

1928

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 192817 I HEREBY CERTIFY That I attended deceased from Feb 12 1928 to Feb 22 1928 that I last saw him alive on Feb 22 1928and that death occurred, on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis(duration) one yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? None(Signed) J. E. Jones M. D.19 (Address) 704 E. 4th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Locust Chapel Cem.

DATE OF BURIAL

20 UNDERTAKER Easton SonsADDRESS Edmond St.



HEALTH DEPARTMENT—CITY OF BALTIMORE **E 30877****E 30877**

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S East Ave ST. 16-7 WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

FILE

1928

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1927, to Feb. 22, 1928, that I last saw him alive on Feb. 22, 1928, and that death occurred, on the date stated above, at 1:45 P. M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 1202  
30878

31 E 30878

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 15-60 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Rita Chance

## (a) RESIDENCE NO.

1655 Thomas Green

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Child

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

January 2, 1920

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 yrs

21

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## BIRTHPLACE (city or town) (State or country)

Ind.

## 10 NAME OF FATHER

Charles Chance

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Bertha Forey

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind.

## Informant (Address)

Rural

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb-23 1928

## 17

I HEREBY CERTIFY, That I attended deceased from Feb-15-1928 to Feb-23-1928.

that I last saw her alive on Feb-23-1928.

and that death occurred, on the date stated above, at 8:55 A. m.

The CAUSE OF DEATH\* was as follows:

Meningitis, tuberculous

(duration) yrs. mos. 23 ds.

## CONTRIBUTORY (Secondary)

Pulmonary tuberculosis

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tubercle bacilli in spinal fluid

(Signed) J. F. Boone, M. D.

Feb. 23 1928 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MORAL

## DATE OF BURIAL

Oak Grove Cath. 2/27 1928

## 20 UNDERTAKER

J. M. Cook

## ADDRESS

807 E. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30879

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 30879

1-PLACE OF DEATH *Room and at*City of BALTIMORE: (No. *John Hopkins Hospital St.* Ward *7-12*)2-FULL NAME *Elizabeth Swickert*(a) RESIDENCE NO. *953 N Chester St*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred *19* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

*19* yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed,

or *Married* (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of *Frank Swickert*

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

35

8 OCCUPATION OF DECEASED

(a) Trade, profession or

particular kind of work *Housewife*

(b) General nature of industry,

business, or establishment in

which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

*Aaron Levinsky*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant *Frank Swickert*

(Address)

*953 N Chester St*

23-1928

C. HAMPSON JONES, M.

Per

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 22/28*

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

*inquiry*find that said deceased came to *her* death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Illuminating Gas Asphyxiation**Suicide*

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) *J. H. Jones*

(Coroner)

M. D.

2/23/28

(Address)

*508 EL North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

In the

of death.....yrs.,.....mos.,.....ds. State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Hebrew Friendship Cem**2 24 19 28*

J. H. JONES

*Jack Lewis 1439 E Balto*

ADDRESS

*St*

30880

## HEALTH DEPARTMENT—CITY OF BALTIMORE

30880

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1427 Battery Ave*

ST.

WARD *31*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Madeleine Bohm*(a) RESIDENCE No. *1427 Battery Ave*

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1904*

7 AGE

Years

Months

Days

*23*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore**md.*

10 NAME OF FATHER

*George R. Bohm*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Mary A. Manning*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore*

14

Informant (Address)

*Mary Downey*  
*1427 Battery Ave*

15

C. HAMPSON JONES, M. D.

Registrar

Filed  
1928

PHT

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 23, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*August 23, 1927*, to *Feb. 23, 1928*,

that I last saw her alive on

*Feb. 22, 1928*

and that death occurred, on the date stated above, at

*9 a. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

*Yes*

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Specimen*

(Signed)

*Thos. J. Jones*

M. D.

1928 (Address)

*2875 Hampden Rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Wm. H. Jones*  
*1318 High**2/27 1928*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30881

## CERTIFICATE OF DEATH.

E 30881

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore Copper Works St. 16-37 Ward 112)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wasil Kovtuniak(a) RESIDENCE NO. 118 A Shell Road

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widower5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Pupman - Balto. Cop. Works

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ukraine

(State or country)

## 10 NAME OF FATHER

Maxim Kovtuniak

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ukraine

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ukraine

## 14

Informant Chas. H. Bachman

(Address)

134 S. Ann St.

## 15 Filled

By

C. HAMPSON JONES, M. D.  
R. R. A. Registrar

1928

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1928

## 17

I HEREBY CERTIFY That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Ac Indigestion  
Errors of Diet

## CONTRIBUTORY

(Secondary)

7th23/28G. C. Bates143 76 Broadway19143 76 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Russia Independent Feb 24 1928

## 20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank

E 30882

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30882

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Sinai Hospital

CITY OF BALTIMORE: (No.

ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Walter Sarsky Or Seracki

(a) RESIDENCE No. 829 S Montford Ave

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

June 3 1926

AGE

Years

Months

Days

If LESS than 1 day, hrs or min

1

8

19

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Walter Seracki

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Sophia Sowa

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

Informant (Address)

Sophia Seracki

829 S Montford Ave.

3 1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/22 1928

17

I HEREBY CERTIFY, That I attended deceased from

2/10

1928, to

2/22

1928,

that I last saw him live on

2/22

1928

and that death occurred, on the date stated above, at

11:55 PM

The CAUSE OF DEATH\* was as follows: 1

Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. Shurdel

M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Stanislaus Ch 25

1928

John M. Weber 1023

Baltimore



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30883

84 E 30883

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 415 S Bond St. St. 3-4 Ward)2-FULL NAME Sophia Ident(a) RESIDENCE NO. 415 S Bond St. St. 3-4 Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)FemaleWhiteSingle6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 25 1919

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.8329

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)School Child

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.10 NAME OF FATHER Luis Ident

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland12 MAIDEN NAME OF MOTHER Mary Mogowska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland14 Luis Ident

Informant

(Address)

415 S Bond St.15 Filed C. HAMPTON JONES M. D.

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1928

17

I HEREBY CERTIFY, That I took charge of the  
remains described above, held in  
(Inquest, autopsy or inquiry.)hereon and from the evidence obtained by said  
Inquest, au-  
topsy or inquiry, and that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Brain Lesion  
Convulsions

(duration)

mos. 1 ds.CONTRIBUTORY  
(Secondary)

(duration)

mos. 1 ds.7/5/28  
23/28  
Signed

(Coroner)

M. D.

(Address)

143 N. Broadway\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVALHoly Rosary Feb 27 1928

20 UNDERTAKER

ADDRESS

John M. Weber 1503 Park

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30884

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 26-37 Ward)

## 2-FULL NAME

J A Y C . B R A D Y

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 6777 Woodlea Rd. Dundalk Md. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. ds. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year)  
July 19, 1906

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	<u>22</u>	<u>7</u>	<u>4</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) Tin Mill

(c) Name of employer Bethlehem Steel Co.

## 9 BIRTHPLACE (city or town)

(State or country) West Virginia10 NAME OF FATHER James Brady11 BIRTHPLACE OF FATHER (city or town)  
(State or country) West Virginia12 MAIDEN NAME OF MOTHER Hulda Belknap13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) West Virginia14 Informant James Brady (Father)  
(Address) Cassaway, W. Va.15 Filed 1928 HAMPSON JONES Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry  
(Inquest, autopsy or inquiry.)thereon had from the evidence obtained by said Inquest, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Multiple FracturesCONTRIBUTORY Bronch. Pneumonia  
(duration) 5 yrs. ds.Feb 23/28 (duration) 1 yrs. ds.  
(Address) 143 B-13ray

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL  
Cassaway, West Virginia Date of Burial Feb. 24 192820 UNDERTAKER  
Henry Sander & Sons Inc. ADDRESS 1710 Fleet St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 30885

30885

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital

2-FULL NAME John Gross

(a) RESIDENCE No. Cor. Henrietta &amp; China St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. One

mos. 19

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 31-31 WARD)

ST. WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Alice Gross

6 DATE OF BIRTH (month, day, and year)

June 1878 da. unk.

7 AGE

Years

Months

Days

If LESS than

49 yrs.

7

unknown

1 day, hrs  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain of boat

(b) General nature of industry, business, or establishment in which employed (or employer) Commerce

(c) Name of employer not known

Calvert Co. Md.

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

John Gross

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Martha Young

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Calvert Co. Md.

Informant

John Gross.

(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21

19 28

17

I HEREBY CERTIFY, That I attended deceased from

2/2

1928

to 2/21

1928

that I last saw him alive on 2/21

1928

and that death occurred, on the date stated above, at 4:55 p m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis, acute miliary

(duration) yrs. one mos. 19 ds.

Myocarditis chronic

CONTRIBUTORY  
(Secondary)

Several years

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? By X-Ray

(Signed)

Feb 24, 1928 (Address) U.S. Marine Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel Cem

20 UNDERTAKER

E L Roy Stuffer

DATE OF BURIAL

Feb 24 1928

ADDRESS

1255 North Ave

1928

C. HAMPSON JONES, M. D.

Registrar

E 30886

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30886

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Memorial Hospital*

REGISTERED NO.

CITY OF BALTIMORE: (No. *12-44*)ST. *12-44* WARD2-FULL NAME *Mrs. Charles W. Brown (Katie)*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *432 W. King*ST. *York Pa.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

*3*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Married*

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Charles W. Brown*

DATE OF BIRTH (month, day, and year)

*Unknown*

AGE

Years

Months

Days

If LESS than  
1 day, .... hrs  
or .... min.*47*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Pennsylvania*

10 NAME OF FATHER

*George Rohler*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Pa.*

12 MAIDEN NAME OF MOTHER

*Nellie Brown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Pa.*Informant  
(Address)*Union Memorial Hos.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 23 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Feb. 20*, 19*28*, to *Feb. 23*, 19*28*,that I last saw her alive on *Feb. 23*, 19*28*,and that death occurred, on the date stated above, at *11.40 P. m.*

The CAUSE OF DEATH\* was as follows:

*Exophthalmic Goiter*(duration) yrs. *9* mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *Yes* Date of *Feb 23, 1928*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Thomas C. Otto*, M.D., 19 (Address) *Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*York Pa*

DATE OF BURIAL

*Feb. 24, 1928*

20 UNDERTAKER

*Wm. J. Huetner Sons*

ADDRESS

*Norfolk Pa*

24 1928

H. J. JONES, M.D.  
*H. J. Jones*  
Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30887

## CERTIFICATE OF DEATH.

143-003  
E 30887

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 12 So. Smallwood St.)2-FULL NAME Emily E. Lorenz(a) RESIDENCE NO. 12 So. Smallwood St.

(Usual place of abode)

Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female4 Color of Race White5 Single, Married, Widowed, or Divorced. (write the word) Married6a If married, widowed, or divorced, HUSBAND of (or) WIFE of John D. Lorenz

6 DATE OF BIRTH (month, day, and year)

July 1st 1903

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

24721

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Home

9 BIRTHPLACE (city or town)

(State or country)

Balto10 NAME OF FATHER Ernest L Bell

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto12 MAIDEN NAME OF MOTHER Henrietta G. Mann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto

14

Informant (Address)

John D. Lorenz  
12 So. Smallwood St.

24 1928

HAMPSON JONES, M.D.  
Physician

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Autopsy

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said AutopsyI find that said deceased came to her death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH is as follows:

Uterine HemorrhageIntra uterine HemorrhageConstitution (duration) Unknown ds.CONTRIBUTORY (Secondary) Internal OrganThos B. Horton (duration) 2 yrs mos.Feb (Signed) Thos B. Horton22 1928 (Address) Curtis Bay

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.,..... mos.,..... ds. In the State..... yrs.,..... mos.,..... ds.

Was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cemetery Feb 24 1928

20 UNDERTAKER

George L. Schmitt 2101 E. 11th St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

B 30888

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital #28*)(ST. *118* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *1823*

(Usual place of abode)

Length of residence in city or town where death occurred

Life mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days *23*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from *2-20-28*, 19*28*, to *2-24-28*that I last saw him alive on *2-24-28*and that death occurred, on the date stated above, at *2:05* PM.

The CAUSE OF DEATH\* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death

Did an operation precede death? *yes* Date of *2-22-28*Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed)

M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

24 1928

C. HAMPTON JONES, M. D. Registrar

George L. Schwab, 3101 E. K. Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30889

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 30889

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 128 Patapsco St. Westport St. Ward)

2-FULL NAME Ludwig Frank.

(a) RESIDENCE NO. 349 Patapsco St. Westport St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 45 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)

Male.

White.

Widower.

5a If ~~widowed~~, ~~XXXXXX~~  
~~HUSBAND of~~  
~~XXXXXXXXXX~~

Bertha R. Frank.

6 DATE OF BIRTH (month, day, and year)

September 25, 1863

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

64

4

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Piano fitter.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Germany.

## 10 NAME OF FATHER

Ferdinand Frank.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

## 12 MAIDEN NAME OF MOTHER

Caroline Karcukie

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany.

14

Informant Frederick A. Frank. (son)

(Address) 349 Patapsco St. Westport.

15 Filed..... 19

J. H. AMBROSIO, Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

February 22, 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry and that said deceased came to his death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Upoplexy.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)(Signed) W. H. Reinhardt, M. D.  
(Coroner)2/22<sup>19</sup> 28 (Address) 1017 E. Charles St.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Western Cem

2/20 1928

## 20 UNDERTAKER

ADDRESS

Geo Leimbach has 525 N. Lyndhurst



*Elba Wise*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30891

## CERTIFICATE OF DEATH.

E 30891

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital* WARD)2-FULL NAME *Elba Wise*(a) RESIDENCE NO. *1120 Linden Ave* ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred *34* yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced? *Widowed* (write the word)

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *December*AGE *58* (58) Years Months Days If LESS than 1 day, his or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *010*

(c) Name of employer

BIRTHPLACE (city or town) *Westfield* (State or country) *Va*10 NAME OF FATHER *John Wise*11 BIRTHPLACE OF FATHER (city or town) *Va* (State or country)12 MAIDEN NAME OF MOTHER *Mary Parker*13 BIRTHPLACE OF MOTHER (city or town) *Va* (State or country)Informant (Address) *1318-73-2-110*

Filed

13200 HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-22 1928*

17

I HEREBY CERTIFY, That I attended deceased from *2-8-*, 19*28*, to *2-22-*, 19*28* that I last saw h. *8* alive on *2-22-*, 19*28* and that death occurred, on the date stated above, at *9:15* m.

The CAUSE OF DEATH\* was as follows:

*Diabetes and Diabetic gangrene of Left foot*  
*Secondary to Diabetes*  
(duration) *subacute* ds.CONTRIBUTORY (Secondary) *myocardial degeneration*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *no* Date of *2-10-28*Was there an autopsy? *no*What test confirmed diagnosis? *Labatory findings*(Signed) *Robert J. Jones* M.D.19 (Address) *Balti City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER *Stannett*

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30892

## CERTIFICATE OF DEATH.

E 30892

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City St. 18-76 Ward)

## 2-FULL NAME

Morris Hardy

## (a) RESIDENCE NO.

1034 Sarah Ann St. 20

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 Color or Race

B.

5 Single, Married, Widowed, or Divorced, (write the word)

S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1882

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

46——

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore City Md

## 10 NAME OF FATHER

Not known

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

## 12 MOTHER'S NAME OF MOTHER

Not known

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

Mr. Wm. H. Hammond 229 Dolphin St.

EB 24 1928

HAYSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 21 1928

17

I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)Hereon and from the evidence obtained by said Inquest and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Second)

(duration)

Exhaustionmos. 4 ds.

(Signed)

(duration)

1st Lt. G. C. B. Gademos. 1 ds.

(Coroner)

M. D.

, 19

(Address)

143 N Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Paul's ChurchFeb 24 1928

20 UNDERTAKER

ADDRESS

Acme Embalming10 E. Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

30893

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 30893

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

632 N. Fremont Ave. 16-23

WARD)

## 2-FULL NAME

Richard B. Wicks

(a) RESIDENCE NO.

632 N. Fremont Ave.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Col.

Married

6a If married, widowed, or divorced HUSBAND of or WIFE of

DATE OF BIRTH (month, day, and year)

18 6 4

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Junior 670

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

Baltimore Md

10 NAME OF FATHER

Richard Wicks

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MOTHER'S NAME OF MOTHER

Barney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pa.

Informant

(Address)

J. H. Davis 632 N. Fremont Ave.

Filed

19

R. H. H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 22 19 28

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1928, to Feb 22, 1928, that I last saw him alive on Feb 22, 1928, and that death occurred, on the date stated above, at 6:05 P. m.

The CAUSE OF DEATH\* was as follows:

\* Myoplexy

(duration)

yrs.

mos

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. A. E. M. D.

24, 1928

(Address)

1006 Edmondson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

W. A. E. M. D.

Feb 24 19 28 916 De an

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30894

## CERTIFICATE OF DEATH.

179 E 30894  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 6-9 Ward)

2-FULL NAME Gladys Jenkins

(a) RESIDENCE NO. 424 N. Register St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.  
(State or country)

10 NAME OF FATHER Henry Jenkins

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Coates

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.  
(State or country)14 Informant Annie Spriggs  
(Address) 236 S. Bethel St

15 Filed 1928 HAYES JONES Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy, or inquiry.)

inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Burns over body and extremities  
Accidentally caught fire from kitchen range.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.  
(Signed) J. S. Butler M. D.  
(Coroner)

2/24/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Crematorium 2/24/28  
Theodore L. White 113 S. ...

## CERTIFICATE OF DEATH.

20 E 30895

**REGISTERED NO.**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 235 N. Fulton Ave., ST. 14 WARD 1)

2-FULL NAME.....Mary Agnes Spellissy

(a) RESIDENCE NO. 235 N. Eglon Ave., ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

### 3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

16 DATE OF DEATH (month, day, and year) Feb. 22, 1928

Female

White

or Divorced, (write)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

17

I HEREBY CERTIFY, That I attended deceased from  
February 17, 1928, to February 22, 1928.

that I last saw h<sup>er</sup> alive on February 22, 1928.

and that death occurred, on the date stated above, at 10<sup>05</sup> p.m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis	5 Years
Chronic Myocarditis	5 Years

(duration) ..... yrs. .... mos ..... ds.

**CONTRIBUTORY**  
(Secondary)

(duration) ..... yrs. .... mos. <sup>prng</sup> 5 ds.

16 Where was disease contracted  
if not at place of death?.....

Did an operation precede death?.....Date of .....

**Was there an autopsy?** .....

What test confirmed diagnosis?

(Signed) Edw. J. Connelley M.D.

19 (Address) *244 U Fuller St*

\*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
--------------------------------------	----------------

NOVAL  
Cathedral Court

2. UNDERTAKER *Deby* 192

NAME	ADDRESS
W. C. UNDERTAKER	316 1/2

**Informant  
(Address)**

**Filed**

## Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30896

179 ✓  
E 30896  
REGISTERED NO.City of BALTIMORE: (No. Johns Hopkins Hospital St. 3-4 Ward)2-FULL NAME Lillian Szlachetka(a) RESIDENCE NO. 518 S. Bond St St.        Ward       

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 22/257 AGE Years 3 Months 3 Days 1 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER

Joseph Szlachetka

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Mary Sebozynski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

14

Informant Father  
(Address)

15 Filed

16

HAMILTON JONES, M.  
R. C. R.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-topsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Burns over Face & body. Accidentally fell in Wash boiler.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) J. H. Jones M. D.

(Coroner)

19 (Address)  
2/24/28508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Stanislaus CemFeb 28<sup>th</sup> 28

20 UNDERTAKER

ADDRESS

Wm Fialkowski1618 Eastern Ave

PARENTS

E 30897

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30897

## 1. PLACE OF DEATH

CITY OF BALTIMORE, (No. *2213 E Biddle* ST. *8-12* WARD)

## 2. FULL NAME

(a) RESIDENCE No. *2213 E Biddle* ST. *8-12* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? yrs. *0* mos. *0* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *Feb 23 1918*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Indl*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Balt Md*10 NAME OF FATHER *Osborne H Walters*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*12 MAIDEN NAME OF MOTHER *Clara M Gupetz*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balt Md*Informant (Address) *Osborne H Walters 2213 E Biddle St*

Filed

19

HAMPSON

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 23 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 23 1928* to *Feb 23 1928*that I last saw him alive on *Feb 23 1928*and that death occurred, on the date stated above, at *40* m.

The CAUSE OF DEATH was as follows:

*Green Bull*  
*Purulent Bull*

CONTRIBUTORY (Secondary)

(duration) yrs. *1* mos. *1* ds.18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *No* Date of *Feb 23 1928*Was there an autopsy? *No*What test confirmed diagnosis? *Findings*(Signed) *John H. Gupetz*Address *5004 Baltimore St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVING

20 UNDERTAKER

ADDRESS

*John H. Gupetz**5004 Baltimore St*



*Lee Goon*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30898

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

*St Joseph's Hospital* ST. *18-24* WARD)

## 2-FULL NAME

*Lee Goon*

(a) RESIDENCE NO.

*38 S. Carrollton*

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *30* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *30* yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M*

4 COLOR OR RACE

*Yellow*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Lail Goon*

6 DATE OF BIRTH (month, day, and year)

*Sept 9 1870*

7 AGE

Years *57*

Months

Days *5*

If LESS than

1 day, hrs.

or min

*58**5**0*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laundry*

(b) General nature of industry, business, or establishment in which employed (or employer)

*041*

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Hong Kong China*

10 NAME OF FATHER

*Lin Kuen*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*China*

12 MAIDEN NAME OF MOTHER

*Yun Kuen*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Hong Kong China*

Informant

(Address)

*Lee Shuen 38 S. Carrollton*

Filed

19

*HAMPTON* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*2-20 1928*

17

I HEREBY CERTIFY, That I attended deceased from *2-15*, 19 *28*, to *2-20*, 19 *28*.that I last saw him alive on *2-20*, 19 *28*.and that death occurred, on the date stated above, at *9.15 P* m.

The CAUSE OF DEATH\* was as follows:

*Marine Angioma*(duration) yrs. mos. *14* ds.

CONTRIBUTORY (Secondary)

*Cardiac Dilatation*(duration) yrs. mos. *1* ds.

18 Where was disease contracted

if not at place of death?

*Home*Did an operation precede death? *yes* Date of *2-18-28*Was there an autopsy? *no*

What test confirmed diagnosis?

*Clinical*

(Signed)

*H. Lawrence Fahmy, M. D.*

1/20, 1928 (Address)

*St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*London Park Cem*

20 UNDERTAKER

*Robert Brooks & Son*

DATE OF BURIAL

*2/27 1928*

ADDRESS

*Calhoun Halline*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30899

## CERTIFICATE OF DEATH.

90 E 30899

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Valencia Theatre. St. 27-48 Ward)2-FULL NAME Mary E. Ray.(a) RESIDENCE NO. 1 Eversham Place Govans. Ward 11

(Usual place of abode)

Length of residence in city or town where death occurred

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Widow.5a If ~~not~~ widowed, or divorced, or separated, (or) WIFE of Charles H. Ray.6 DATE OF BIRTH (month, day, and year) July 16, 18537 AGE Years 74 Months 7 Days 6. IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town).....

(State or country) West Virginia.10 NAME OF FATHER Benjamin F. Steel.

## 11 BIRTHPLACE OF FATHER (city or town).....

(State or country) West Virginia.12 MAIDEN NAME OF MOTHER Amanda Johnson.

## 13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) West Virginia.14 Informant Virginia Mooney (daughter)  
(Address) 1 Eversham Place Govans.15 Filed..... 19 1928 Registrar W. H. R. H.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 22, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic disease of the heart.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) Edo M. Reinhardt

(Coroner)

2/24/1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cemetery Date of Burial Feb 23-1928

## 20 UNDERTAKER

Robt J. Turner ADDRESS 1000 N. Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30900

## CERTIFICATE OF DEATH.

E 30900

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 h. Mount ST. 15-21 WARD)2-FULL NAME Milton Peterson(a) RESIDENCE NO. 1425 h. Mount ST.,

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 4 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 4 yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Camille Peterson6 DATE OF BIRTH (month, day, and year) June 1902

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) See County  
(State or country) South Carolina10 NAME OF FATHER Richard Peterson11 BIRTHPLACE OF FATHER (city or town) See Co.  
(State or country) South Carolina12 MAIDEN NAME OF MOTHER Elizabeth Robinson13 BIRTHPLACE OF MOTHER (city or town) See Co.  
(State or country) South CarolinaInformant Camille Peterson  
(Address) 1425 h. MountFiled 1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 13, 1928 to Feb 22, 1928, that I last saw him alive on Feb 21, 1928.and that death occurred, on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH\* was as follows:

acute lobar pneumonia(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of deathDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physiological report(Signed) John E. S. Chamber M. D., 19 (Address) 1425 h. Mount

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg St

DATE OF BURIAL

Feb 24 1928

20 UNDERTAKER

ADDRESS

LaBorne & Son108 m. Mount

E 30901

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30901  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 22-31 Pronounced dead at the South Baltimore General Hospital. Ward)2-FULL NAME William Johnson.(C)(a) RESIDENCE NO. 211 W. Montgomery St. St.        Ward         
(Usual place of abode) (If no -resident give city or town and State)Length of residence in city or town where death occurred 25 yrs.        mos.        ds.  
(If no -resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 Color or Race Colored 5 Single, Married, Widowed,  
or Divorced. (write the word) Married.5a If married, ~~XXXXXXXXXXXX~~  
HUSBAND of Henrietta Johnson.  
~~XXXXXXXXXX~~6 DATE OF BIRTH (month, day, and year)  
January 6, 18807 AGE Years 48 Months 1 Days 15 IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Laborer 40(b) General nature of industry,  
business, or establishment in  
which employed (or employer)       (c) Name of employer       9 BIRTHPLACE (city or town) Calvert Co., Md.  
(State or country)10 NAME OF FATHER William Johnson.(C)11 BIRTHPLACE OF FATHER (city or town) Calvert Co., Md.  
(State or country)12 MAIDEN NAME OF MOTHER Eliza Diggs.(C)13 BIRTHPLACE OF MOTHER (city or town) Calvert Co., Md.  
(State or country)14 Informant Bertha Johnson.(C) daughter  
(Address) 1004 Warner St.15 Filed        15        Registrar       

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)  
February 21, 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest, au-  
inquiry find that said deceased came to his death  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Internal injuries. Struck in the chest  
by explosion of a tank.  
Occidental Death.(duration)        yrs.        mos.        ds.CONTRIBUTORY  
(Secondary)(duration)        yrs.        mos.        ds.  
(Signed) Otho M. Finckel M. D.  
(Coroner)2/28 19 28 (Address) 1017 E. Charles St.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place of death        yrs.        mos.        ds. In the        yrs.        mos.        ds.Where was disease contracted, if not at place of death? Leveering Plant. Key Highway & WilliamFormer or usual residence Feb. 21, 192819 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL St. John's Calvert Co Feb 29, 1928

20 UNDERTAKER

ADDRESS

St. Brown & Son108 W. Main

## HEALTH DEPARTMENT—CITY OF BALTIMORE

30902

## CERTIFICATE OF DEATH.

x197 E 30902

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 4-7 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Bertha Collins.(a) RESIDENCE NO. 129 Leeds Ave. Arbutus. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Married.5a If married, ~~XXXXXX~~ XXXXXX  
(or) WIFE of Frank Collins.6 DATE OF BIRTH (month, day, and year) August 24, 1882.7 AGE Years Months Days IF LESS than  
45 5 29 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(n) Trade, profession or particular kind of work None.

(h) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

## 9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.10 NAME OF FATHER Albert Kassakatis.11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Germany.12 MAIDEN NAME OF MOTHER Elizabeth Schuster.13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) Baltimore, Md.14 Informant Joseph Leitzer. (son)  
(Address) 3634 Church Ave.15 Filed 1925 Registrar George W. Zirkler

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1925  
February 22, 192517 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said autopsy  
(Inquest, au-  
topsy or inquiry.) and inquest her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Internal hemorrhage. Due to pistol  
shot wound of the back.  
Homicide.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)(duration) yrs. mos. ds.  
(Signed) Edw. McFarland M. D.  
(Coroner)2/24/25 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

where was disease contracted, if not at place of death

1000 block Guilford Ave. Feb. 21, 1925

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lowdon Park Cemetery Date of Burial 2/25 1925  
ADDRESS 1737 Eager

## 20 UNDERTAKER

George W. Zirkler



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30903

E 30903

REGISTERED NO.

City of BALTIMORE: (No. 400 Fulton Ave St. 70-27 Ward)

2-FULL NAME

John Severe

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Home for the Aged of the M.E. Church Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 1 mos. 1 ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

June 24 - 1844

7 AGE

Years

Months

Days

83728IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Retired Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Somersetshire England

10 NAME OF FATHER

George Severe

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

12 MAIDEN NAME OF MOTHER

Mary Papples

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

England

14

Informant

Etta Cuddy

(Address)

400 N. Fulton Ave.

15

Filed

1928R. H. H.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 22 - 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 7, 1928, to Feb 22, 1928,that I last saw him alive on Feb 21, 1928,and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Septicemia(duration) 3 yrs. 1 mos. 1 ds.CONTRIBUTORY  
(Secondary)Cardiac conditions  
Arterio Sclerosis(duration) 1 yrs. 6 mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Clinical methods

(Signed)

Geo. E. Shannon

M. D.

7/23, 1928 (Address)

700 Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt. Olivet CemeteryFeb. 24, 1928

20 UNDERTAKER

George J. Smith

ADDRESS

1532  
Hollins St.

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 30904

## CERTIFICATE OF DEATH

E 30904

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1015 Peach St., 23-31 Ward)

## 2-FULL NAME

Charles Demby

## (a) RESIDENCE NO.

1015 Peach St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. - mos. - ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

Col

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Mary Demby

## 6 DATE OF BIRTH (month, day, and year)

Oct - 26, 1887

## 7 AGE

Years  
40Months  
3Days  
26IF LESS than  
1 day hrs.  
or min..

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Laborer 440

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

Swift Surtzly Co

## 9 BIRTHPLACE (city or town)

Centerville

## (State or country)

Maryland

## 10 NAME OF FATHER

Henry Demby

## 11 BIRTHPLACE OF FATHER (City or town)

Centerville

## (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Albata Turner

## 13 BIRTHPLACE OF MOTHER (city or town)

Chestertown

## (State or country)

Maryland

## 14

Informant  
(Address)Sula Brown  
1015 Peach St.

## 15 Filed, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

2/21 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

11/29, 1927, to 2/20, 1928.

that I last saw him alive on 2/20, 1928.

and that death occurred, on the date stated above, at 10:30 a.m.

## The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed)

Daw Francis M. D.

27. 1928 (Address)

125 E Lee St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## Date of Burial

Mt Auburn Cem

2/24/28

## 20 UNDERTAKER

## ADDRESS

Samuel Hensley

125 E Lee St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30905

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Dismal Hill av ST. 17-24 WARD)

## 2-FULL NAME

(a) RESIDENCE. No. 930 Dismal Hill av ST. 17-24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

65 Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town  
(State or country))

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 10, 1927, to Aug 22, 1928.

that I last saw him alive on Aug 21, 1928.

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH\* was as follows:

Organic heart disease  
(narrow aorta)

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY  
(Secondary)

(duration) 25 yrs. — mos. — ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. exam.

(Signed) Chas. Keller, M. D.

19 (Address) 222 W. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30906

## CERTIFICATE OF DEATH.

E 30906

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *1108 1/2 St.* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

8 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

2-19-28, 19 to 2-21-28, 19

that I last saw him alive on 2-21-28

and that death occurred, on the date stated above, at 6:05 p.m.

The CAUSE OF DEATH\* was as follows:

Intestinal obeligitin  
(old post operation adhesion)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2-19-28

Was there an autopsy? yes

What test confirmed diagnosis? phy. pathy  
(Signed) E. J. H. M. D.

, 19 (Address) Mary Hospital

\*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30907

## CERTIFICATE OF DEATH

129 E 30907

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Provident Hospital*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *316 Canon*St. *Westmoreland* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. *18* mos. *18* ds. How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

*Female* *Colored* *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1851*

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

*77*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*none*

9 BIRTHPLACE (city or town)

(State or country)

*Ind.*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*

14

Informant (Address)

*Hospital Records*

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 23 28*

17

I HEREBY CERTIFY, That I attended deceased from

*2/4/28*, 19*28*, to *2/23/28*, 19*28*that I last saw him alive on *2/23/28*, 19*28*and that death occurred, on the date stated above, at *6:20 P.M.*

The CAUSE OF DEATH\* was as follows:

*Uremia*

CONTRIBUTORY

(Secondary)

(duration) *unknown**Chronic nephritis*(duration) *unknown**arteriosclerosis*

18 Where was disease contracted

if not at place of death?

*unknown*

Did an operation precede death?

Date

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*John H. Langer, M.D.*

(Address)

*Provident Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

Date of Burial

REMOVAL

20 UNDERTAKER

ADDRESS

*Phila. Co. 7/23/28*  
*Samuel Hunsley*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30908

## CERTIFICATE OF DEATH.

E 30908

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17-24 ST. 101 WARD)2-FULL NAME James J. Jones

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 924 Wilkes Alley

(Usual place of abode)

## WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

MaleCaucasianMarried5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of?

## 6 DATE OF BIRTH (month, day, and year)

?

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.52

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workSalvage 240(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## (c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Baltimore  
Maryland10 NAME OF FATHER J. J. Jones

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

W. J. Jones12 MAIDEN NAME OF MOTHER Anna D. Jones

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## Informant

(Address)

Records

Filed

19

HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/1928

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 21, 1928 to Dec. 22, 1928that I last saw him live on Dec. 22, 1928,and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH\* was as follows:

Subar pneumonia(duration) yrs. mos. 5 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted?  
if not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? General & Sub(Signed) C. J. Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR  
DISPOSALSt. Ambrose

## 20 UNDERTAKER

Samuel Hensley

## DATE OF BURIAL

2/26/28

ADDRESS

Middle

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 30909

E 30909

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4101 Overlea Ave. ST., Overlea WARD)

## 2. FULL NAME

Emma G. Yearley

## REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

4101 Overlea Ave. ST., Overlea WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White

## 4 COLOR OR RACE

## 5 Single, Married, Widowed,

or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

William N. Yearley

## 6 DATE OF BIRTH (month, day, and year)

May 17<sup>th</sup> 1844

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs

or min.

83911

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Alexandria

(State or country)

Virginia

## 10 NAME OF FATHER

James B. Hall

## 11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

Virginia

## 12 MAIDEN NAME OF MOTHER

Ann Eliza Cox

## 13 BIRTHPLACE OF MOTHER (city or town)

St. Marys

(State or country)

Maryland

## Informant

William N. Yearley

(Address)

4101 Overlea Ave. Overlea

## Filed

19

C. H. JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 22 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

, 19 20, to Feb. 22, 19 28.that I last saw her alive on Feb. 22, 19 28.and that death occurred, on the date stated above, at 9:50 m.

The CAUSE OF DEATH\* was as follows:

Cerebral arterio-sclerosis with softening

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of overWas there an autopsy? No

## What test confirmed diagnosis?

(Signed) Ernest M. Smith, M. D.2/13, 1928 (Address) 2430 Maryland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

St. Olivet CemeteryFeb. 25, 1928

## 20 UNDERTAKER

## ADDRESS

Frederick Bassett Sons Fullerton

E 30910

## HEALTH DEPARTMENT—CITY OF BALTIMORE

30910

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *231-W-Lanvale* ST. *11-24* WARD)2-FULL NAME *Emma Virginia Watkins*(a) RESIDENCE No. *231-W-Lanvale* ST., WARD *Resident*

(Usual place of abode)

Length of residence in city or town where death occurred *76* yrs. — mos. — ds.How long in U. S., if of foreign birth? *76* yrs. — mos. — ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *About-1852*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *About 76 ? ?*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *none*(c) Name of employer *none*9 BIRTHPLACE (city or town) (State or country) *Balto. Maryland*10 NAME OF FATHER *Geo. W. Watkins*11 BIRTHPLACE OF FATHER (city or town) (State or country) *unknown Maryland*12 MAIDEN NAME OF MOTHER *Jane - ? ? ?*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *unknown Maryland*Informant *William Ingle - (Friend)*(Address) *1710 Park Ave. City*

Filed

19

Registrar *Wm*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 23<sup>rd</sup> 1928*

17

I HEREBY CERTIFY That I attended deceased from *Dec*, 1927, to *Feb 23<sup>rd</sup> 1928*, that I last saw *her* alive on *Feb 23<sup>rd</sup> 1928*, and that death occurred, on the date stated above, at *6<sup>30</sup>-a m*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*(duration) yrs. mos. ds. *7*CONTRIBUTOR *General Arterio Sclerosis*

(Secondary)

(duration) yrs. mos. ds. *3*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Howard J. Hughes*, M. D.13, 1928 (Address) *1211 Eutan Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Landon Post Family Feb 23<sup>rd</sup> 1928*  
*Stewart Mowen Balto.*

E 30911

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 30911

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 620 E. 41st. Street

St. 9-47 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sebastian McCormick

(a) RESIDENCE NO. 620 E. 41st. Street

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

::: :::

6 DATE OF BIRTH (month, day, and year)

Sept. 3rd 1860

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

67

5

19

8 OCCUPATION OF DECEASED

(a) Trade, profession Retired  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Oil Business

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore Md.

(State or country)

10 NAME OF FATHER

Patrick McCormick

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Morrissey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant

John McCormick

(Address)

620 E. 41st. Street

15 Filed

23-24-1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

February 22

17

I HEREBY CERTIFY, That I attended deceased from

19 20

to Feb. 22

19 28

that I last saw him alive on

Feb. 21

19 28

and that death occurred, on the date stated above, at 11 45 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of sigmoid

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Carcinoma of stomach  
leucemia (metastatic)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

No

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Strong M. D.

M. D.

2/23 19 28 (Address)

2435 Maryland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Peter's Cemetery

2/25/28 19

20 UNDERTAKER

ADDRESS

Chas. P. Evans &amp; Son 1180 Mt. Royal



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

347  
211 E 30912  
1-PLACE OF DEATH

32 E 30912

CITY OF BALTIMORE: (No. 3-4 WARD)

2-FULL NAME Henry Ernest

(a) RESIDENCE No. 225 S. Caroline  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-1-24

7 AGE 3 1/2 Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ind

10 NAME OF FATHER Henry Ernest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Annie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

Informant Parents  
(Address)

Filed

1928 Rev. M. J. Jones, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb-20, 1928, to Feb-23, 1928, that I last saw him live on Feb-23, 1928, and that death occurred, on the date stated above, at 12:06 P.M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia, left lung, primary

(duration) yrs. mos. 12 ds.

CONTRIBUTORY Tuberculosis meningitis  
(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Examination Spinal fluid

(Signed) J. B. Jones M. D.

(Address) John Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mount Carmel  
Wendell J. Hyslop

Feb 25 1928  
3001 Calumet



## HEALTH DEPARTMENT—CITY OF BALTIMORE

30913

E 30913

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST., 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine O'Connell(a) RESIDENCE No. 221 W. Seawater ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds.How long in U. S., if of foreign birth? 7 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleWhiteMarried

5a If married, widowed, or divorced

HUSBAND of

or) WIFE of

Roger O'Connell6 DATE OF BIRTH (month, day, and year) ?

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.42

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

Pennsylvania10 NAME OF FATHER Wm. J. Quinn

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland12 MAIDEN NAME OF MOTHER Catherine Sullivan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

Informant

(Address)

Records

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 26, 1928, to Feb. 22, 1928.that I last saw him live on Feb. 22, 1928,and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis.arterio-sclerosishypertension(duration) 3 yrs. 3 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) ? yrs. ? mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? General & Sub(Signed) C. Stevens Borge M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

Feb. 25, 1928.

ADDRESS

3011 Calver

## HEALTH DEPARTMENT—CITY OF BALTIMORE

30914

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 6-9 WARD)2-FULL NAME Denise Ellen Miller(a) RESIDENCE No. 1527 Orleans ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?7 AGE Years Months Days If LESS than 1 day, hrs. or min. 6 2

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER John Campbell11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Esther13 BIRTHPLACE OF MOTHER (city or town) (State or country) MarylandInformant (Address) Revised

Filed

1928 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20/192817 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1927, to Feb. 20, 1928, that I last saw him alive on Feb. 20, 1928, and that death occurred, on the date stated above, at 12:00 p.m.

The CAUSE OF DEATH\* was as follows:

Subacute pneumonia(duration) yrs. mos. ds. 3CONTRIBUTORY (Secondary) Paralysis agitans

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? General & Sub(Signed) C. Swensson Bryan, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Asbury cemetery

DATE OF BURIAL

Feb 24, 1928

20 UNDERTAKER

Edward BryanADDRESS 1684Orleans St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30915

## CERTIFICATE OF DEATH.

E 30915  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 75 Mallon Hill St. 28-66 Ward)2-FULL NAME Ethel Mary Eider(a) RESIDENCE NO. 75 Mallon St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) Divorced6a ~~Married~~ or divorced HUSBAND of Carl (or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb. 2 - 18977 AGE Years 31 Months - Days 21 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

## 15

Filed..... 19.....

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 192817 I HEREBY CERTIFY that I am in charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)thereof and from the evidence obtained by said Autopsy (Inquest, au-topsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pul. T.B.(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

1st. E. C. Gladue (duration) 1 yrs. 1 mos. 1 ds.(Signed) E. C. Gladue M. D.(Address) 1430 Bway

\*Since the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Howard Co Md19 PLACE OF BURIAL, CREMATION, OR REMOVAL St. Johns Cemetery Date of Burial Feb. 26 192820 UNDERTAKER Carl M. Starr ADDRESS Edgewater Md.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30916

## CERTIFICATE OF DEATH.

44 E 30916

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3608 Maple Ave. 13<sup>th</sup> Ward)2-FULL NAME Mary F. Hann(a) RESIDENCE NO. 3608 Maple Ave. St. 13 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of Robert R. Hann  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 3, 1874

7 AGE Years Months Days 19 IF LESS than 1 day.....hrs. or.....min.  
53 9 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer..... At Home

9 BIRTHPLACE (city or town)..... Manchester

(State or country)..... Maryland

10 NAME OF FATHER Josh Coltritter

11 BIRTHPLACE OF FATHER (city or town)..... Manchester

(State or country)..... Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)..... Unknown

14 Informant Mr. George W. Hann

(Address) 6003 Falls Road

15 Filed....., 19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/22 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy, or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cancer  
Homer

CONTRIBUTORY (Secondary)

(duration).....yrs. ....mos. ....ds.  
(Signed)..... M. P.  
(Coroner)

7/23, 1928 (Address) 7692 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cemetery

Date of Burial

Feb. 25, 28

20 UNDERTAKER

ADDRESS

1003 West

Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30917

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 8-16 WARD)2-FULL NAME Frederick Mohr(a) RESIDENCE NO. 1313 W. Millin Ct. WARD(Usual place of abode)  
Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.129 E 30917  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Anna Mohr6 DATE OF BIRTH (month, day, and year) Oct 28-18917 AGE Years 36 Months 4 Days 4 If LESS than 1 day, 0 hrs. 0 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 086BIRTHPLACE (city or town)  
(State or country) Maryland10 NAME OF FATHER John Mohr11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Anna13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) MarylandInformant  
(Address) RecordsFiled 21 1928 19 HANSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/192817 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1927 to Feb. 22, 1928that I last saw him alive on Feb. 22, 1928and that death occurred, on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH\* was as follows:

hepatitis - chronic inter-  
stitial. myocarditis - chronic  
arteriosclerosis. Hypertension\* (duration) 7 yrs. 0 mos. 0 ds.CONTRIBUTORY  
(Secondary)(duration) 0 yrs. 0 mos. 0 ds.18 Where was disease contracted  
if not at place of death? ?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Subc(Signed) C. J. Volmer, M. D., 19 086 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL  
Holy Redeemer

## DATE OF BURIAL

Feb 25 1928

## 20 UNDERTAKER

Geo W. Fennell

## ADDRESS

811 New York



E 30918

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30918

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 North Ave Mt Washington Hill ST WARD)

## 2-FULL NAME

Babbette Jeanne Cassell

(a) RESIDENCE No. 2002 N. North on Mt Washington ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Mr Barry Cassell

6 DATE OF BIRTH (month, day, and year) Sept 21<sup>st</sup> 1887

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

40

5

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Rich

France

10 NAME OF FATHER

Harrison Lamm

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

France

12 MAIDEN NAME OF MOTHER

Emily Dodge

1824<sup>th</sup>, 1928 (Address)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Richmond  
Virginia U.S.AInformant  
(Address)

W Barry Cassell

2002 North Ave Mt Washington Hill

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23<sup>rd</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from

8

19

to

19

that I last saw him alive on Feb 23<sup>rd</sup>

1928

and that death occurred, on the date stated above, at

4<sup>30</sup> P. m

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis with Extensive  
Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical findings

(Signed)

Mr M. Dabney

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Brimm Ridge Cem

Feb 25 1928

20 UNDERTAKER

ADDRESS

J. W. JENKINS &amp; SONS CO.

Cecil

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30919

## CERTIFICATE OF DEATH.

31 ✓  
E 30919

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 716 N. Eden 10-14 Ward)2-FULL NAME Garland E. Egleson(a) RESIDENCE NO. 716 N. Eden St. St. 10 Ward 14

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race colored 5 Single, Married, Widowed, or Divorced, (write the word) single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr 6 19107 AGE Years 17 Months 10 Days 19 IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Prince Edward Va10 NAME OF FATHER David Egleson11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Va12 MAIDEN NAME OF MOTHER William Watson13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Va14 Informant Delia Brown  
(Address) 716 N. Eden St15 Filed 1928 19 11 11 Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 192817 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927, to Feb 23, 1928, that I last saw him alive on Feb 22, 1928, and that death occurred, on the date stated above, at 7:55 A.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
7 yrs. 7 mos. 0 ds.CONTRIBUTORY Pulmonary Hemorrhage  
(Secondary)(duration) 10 yrs. 10 mos. 10 ds.

18 Where was disease contracted

If not at place of death? ✓Did an operation precede death? no Date of.....Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Stinner, M. D.2-23-1928 (Address) 1612 E. Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wesleyan Date of Burial Feb 23 192820 UNDERTAKER Wm H. Cusack ADDRESS 1500 N. Green

## HEALTH DEPARTMENT—CITY OF BALTIMORE

30920

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Merry Hospital* ST. *15-60* WARD)2-FULL NAME *Baby Boy Leroy*(a) RESIDENCE NO. *1636 Maryland Ave*

(Usual place of abode)

WARD

REGISTERED NO. *30920*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *2/19/28*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER *Solomon Leroy*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Lillian Feldman*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/23/28*

17

I HEREBY CERTIFY, That I attended deceased from  
*2/19*, 19 *28*, to *2/23*, 19 *28*.that I last saw him alive on *2/23*, 19 *28*.and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage  
Congenital malformation*

(duration)

yrs.

mos.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Ervin B. Wallace*, M. D.

, 19

(Address) *Merry Hosp. Balto Md.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVING

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*New Friendship**2-24-19 28**Jack Lewis, 1437 E. Balto*



30922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30922

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp 27-43 ST., WARD)2. FULL NAME Mr. Adam Turk

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3014 Glenmore Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 40 mos. 40 ds.How long in U. S., if of foreign birth? 2 yrs. 2 mos. 2 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofMrs Adam Turk6 DATE OF BIRTH (month, day, and year) Aug 7, 1868

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.64615

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bot Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

Bot Manufacturer

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Germany10 NAME OF FATHER Sebastian Turk11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Germany12 MAIDEN NAME OF MOTHER Elizabeth Butte13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)GermanyInformant  
(Address)Hospital Records

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 23, 1928, to Feb 22, 1928,  
that I last saw him alive on Feb 22, 1928,and that death occurred, on the date stated above, at 11 40 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Yes Date of Jan 26, 1928

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. J. Seraghty M. D.

, 19

(Address)

Union Memorial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London ParkFeb 25 1928

20 UNDERTAKER

ADDRESS

Mr. & Mrs. John W. Tupper & Son 801 W. Fayette



E 30923

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31

E 30923

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1570 Maderia ST. 8-16 WARD)

## 2-FULL NAME

Leroy B. Morrow

## (a) RESIDENCE NO.

1570 Maderia

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

## 6 DATE OF BIRTH (month, day, and year)

Dec. 26 - 1899

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

28

1

27

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Sheet Metal Worker

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Charles T. Morrow

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

## 12-MAIDEN NAME OF MOTHER

Hannie Batzer

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

## Informant (Address)

Chas. T. Morrow, 1570 Maderia St.

## 15

## Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 22, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 11, 1928, to February 22, 1928.

that I last saw him alive on February 21, 1928,

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH\* was as follows:

Phthisis Pulmonalis

(duration) 2 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Filmatry test

(Signed) H. H. Singmaster, M. D.

(Address) 1613 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

## DATE OF BURIAL

Feb 25, 1928

## 20 UNDERTAKER

Mr. &amp; Mrs. John W. Gifford

## ADDRESS

801 N. Fayette

E 30924

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30924

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1629 E. 31st St.)

St. 9-46 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME H. Isabell Burk Gans

(a) RESIDENCE NO. 1629 E. 31st

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ornesta Burk

6 DATE OF BIRTH (month, day, and year)

Sept 13/65

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

62

5

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Morrisville, Pa

## 10 NAME OF FATHER

William Clark

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

W. Va

## 12 MAIDEN NAME OF MOTHER

Elma Fort

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

U. S. A

14

Informant (Address)

Chola Schueg 1629 E. 31st

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

February 22nd 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 10 1928, to Feb 22nd 1928.

that I last saw him alive on Feb 22nd 1928.

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. 12 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Robert S. Kirk M. D.

(Address)

3126 Harford Rd

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Pk

7/25 1928

## 20 UNDERTAKER

ADDRESS

K. Neumann

37 S Bway

Filed Feb 24 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

30925

30925

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST., *7-12* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. *1102 N. Kenwood Ave.* ST., *7-12* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *44* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE *44* Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Carpenter*(b) General nature of industry, business, or establishment in which employed (or employer) *015*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto.*10 NAME OF FATHER *Jos. H. Mitchell*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Charleston Co. Md.*12 MAIDEN NAME OF MOTHER *Philomena Miranda*13 BIRTHPLACE OF MOTHER (State or country) *St. Augustine Fla.*14 Informant (Address) *Mrs. Felix Diccio*15 Filed *27 1928*

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) *2/23/1928*17 I HEREBY CERTIFY, That I attended deceased from *2/21/28*, 19 *28*, to *2/23/28*, 19 *28*, that I last saw him alive on *2/22/28*, 19 *28*, and that death occurred, on the date stated above, at *7 P.* m.

The CAUSE OF DEATH\* was as follows:

*wrenna*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *cardiac dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *T. P. T. Thompson*, M. D.19 (Address) *St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Wm. McKuer Sons**North Sta*

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 30926

E 30926

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3500 Hickory Ave

ST. 12-52 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Rosa B. Wallis

## (a) RESIDENCE NO.

3500 Hickory Ave

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

30

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John C. Wallis

## 6 DATE OF BIRTH (month, day, and year)

May 14-1865

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

62

9

9

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

At home - 200

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Talbot Co. Md.

## 10 NAME OF FATHER

Samuel J. Burns

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Susan E. Cheers

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

## Informant (Address)

John M. Wallis  
3531 Roland Ave.

## Filed

1928

C. HAMPTON JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 23rd 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 17th, 1928, to Feb 23rd, 1928

that I last saw her alive on Feb 23rd, 1928

and that death occurred, on the date stated above, at 3:00 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Stenosis Log E.

CONTRIBUTORY (duration) yrs. mos. 7 ds.  
(Secondary) arteriosclerosis High B.P.  
Hypertension (duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical &amp; Physiological

(Signed)

J. Q. Piller M. D.

7/3, 1928 (Address)

1015 Fairview Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

St. Mary's (Hampton)

Feb. 25, 1928

## 20 UNDERTAKER

## ADDRESS

George H. Burgee

1015 Fairview Rd



E 30927

HEALTH DEPARTMENT—CITY OF BALTIMORE E 30927

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *6006 Henderson Ave.* *27-48* Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Florence May Kelly*(a) RESIDENCE NO. *6006 Henderson Ave.* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *34* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Apr 21. 1893*7 AGE Years *34* Months *10* Days *1* IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Secretary Penn Luth. Co.*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) *Balti Md*  
(State or country)10 NAME OF FATHER *John Kelly*11 BIRTHPLACE OF FATHER (City or town) *Md*  
(State or country)12 MAIDEN NAME OF MOTHER *Anna Day*13 BIRTHPLACE OF MOTHER (city or town) *Balti Md*  
(State or country)14 Informant *Mrs. Anna C. Jackson*  
(Address) *6006 Henderson Ave*15 Filed \_\_\_\_\_ 19 \_\_\_\_\_ Registrar *John Mitchell*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 22nd.* 19 *28.*17 I HEREBY CERTIFY, That I attended deceased from *Feb 8*, 19*28*, to *Feb 22*, 19*28*.that I last saw *her* alive on *Feb 22*, 19*28*.and that death occurred, on the date stated above, at *2:15 P M*.

The CAUSE OF DEATH\* was as follows:

*Cancer of Breast - metastasis in lungs -*(duration) *3* yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) \_\_\_\_ yrs. mos. ds.

18 Where was disease contracted

If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? *Harry S. McCreary*, M. D.

(Signed) \_\_\_\_\_

2-22-1928 (Address) *37 W. Chestnut St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*New Cathedral Church Feb 25 1928*

20 UNDERTAKER

ADDRESS

*John Mitchell 1900 Calver Pl*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30928

E 30928

## CERTIFICATE OF DEATH

75-001  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4003 Keswick Road St. 3 Ward 4)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bowers Kerwin(a) RESIDENCE NO. 4003 Keswick Road St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of General Michael Kerwin6 DATE OF BIRTH (month, day, and year) Aug 18. 18487 AGE Years 82 Months 6 Days 6 IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Penna

(State or country)

10 NAME OF FATHER Thomas Bowers11 BIRTHPLACE OF FATHER (City or town) Penna

(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Marples13 BIRTHPLACE OF MOTHER (city or town) Penna

(State or country)

14 Informant Chas H. Lenville  
(Address) 4003 Keswick Road15 Filed 1928 19 \_\_\_\_\_Registrar John O. Mitchell

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24. 192817 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to Feb. 24, 19\_\_\_\_.that I last saw her alive on Feb. 24, 19\_\_\_\_.and that death occurred, on the date stated above, at 10. A. M.

The CAUSE OF DEATH\* was as follows:

Hemiplegia

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. Lutscher, M. D.19 (Address) 12 E. Eager St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid RidgeDate of Burial Feb. 27 192820 UNDERTAKER John O. MitchellADDRESS 12 E. Eager St

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 30929

E 30929

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3016 Abell Ave. St. 12-50 Ward)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Charles Gordon Knobloch

(a) Residence No. 3016 Abell Ave. St. .... Ward. ....  
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 8 mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

June 13/1924

7-AGE,

3 yrs. 8 mos. 10 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

000

(c) Name of employer.

Baltimore

9-BIRTHPLACE (city or town) (State or Country),

Baltimore Md

10-NAME OF FATHER,

Chas. M. Knobloch

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER,

Selma E. Bayler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

Baltimore Md

14-

(Informant),

Chas. M. Knobloch

(Address),

3016 Abell Ave.

15-

Filed,

C. HAMPSON JONES, M. D.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-23<sup>rd</sup>/1928

17- I HEREBY CERTIFY, That I attended deceased from

2-21<sup>st</sup> 1928, to 2-23<sup>rd</sup> 1928that I last saw him alive on 2-23<sup>rd</sup> 1928,

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY Probably Tuberculosis (Secondary) Disinfect 1 1/2 years duration

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Russell Long M. D.

19 (Address) 2937 N. Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

Parkwood Cem. Feb. 25, 1928

20-UNDERTAKER

Wm. H. Huerfoss North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30930

E 30930

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 East Hoffman ST., 9-18 WARD)2. FULL NAME Rose A Dehuff(a) RESIDENCE NO. 1010 East Hoffman ST., WARD

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
or WIFE ofRobert Dehuff6 DATE OF BIRTH (month, day, and year) Jan 1 - 1881

7 AGE

47

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Baltimore Md

10 NAME OF FATHER

Thomas Drane11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Ireland

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)IrelandInformant  
(Address)Robert Dehuff  
1010 East Hoffman

Filed

49

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1928

17

I HEREBY CERTIFY, That I attended deceased from

2/11, 1928, to2/23, 1928.that I last saw her alive on 2/23, 1928.and that death occurred, on the date stated above, at 1050 A m.

The CAUSE OF DEATH\* was follows:

Chronic MyocarditisChronic Nephritis(duration) ? yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) 12 yrs. mos. ds.18 Where was disease contracted  
if not at place of death? 1010 - E - HoffmanDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? To special tech(Signed) Jack A. Morgan M. D.2/23/28 (Address) 6 - E - Glad St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Carthood Cemetery

DATE OF BURIAL

2/25 1928

20 UNDERTAKER

William Cook

ADDRESS

502 E North An

E 30931

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

84 E 30931

1-PLACE OF DEATH *Franklin Square Hosp.*CITY OF BALTIMORE: (No. *Gillman's Alley* ST., *8-16* WARD)2-FULL NAME *Evelyn Elizabeth Wiegand*(a) RESIDENCE NO. *2212 Preston Place* ST., *8-16* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *14* mos.

ds. How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 16, 1926*7 AGE Years *1* Months *2* Days *8* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *infant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *md.*10 NAME OF FATHER *Frederick Wiegand*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *md.*12 MAIDEN NAME OF MOTHER *Katherine Eberwein*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *md.*14 Informant *Frederick Wiegand* (Address) *2212 Preston Place*15 Filed *19* *HAMMON JONES, M.D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 24 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 11*, 19 *28*, to *Feb. 24*, 19 *28*, that I last saw her alive on *Feb. 24*, 19 *28*, and that death occurred, on the date stated above, at *3:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Psychitis & possible menia*(duration) yrs. *20* mos. ds.CONTRIBUTORY *Little's Disease (Spastic)* (Secondary) *Paraplegia* (duration) yrs. *14* mos. ds.18 Where was disease contracted *Home* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Evelyn B. Shuman* M. D., 19 (Address) *Franklin Sq. Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Baltimore Cemetery**2/27 1928*

UNDERTAKER

ADDRESS

*William Cook**502 E North*

E 30932

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30932

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

## 2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

col

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 21-1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Everett Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Ella Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

Everett Elliott 251 N. Schroeder St

15

Filed

19

C. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 23 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 22, 1928, to Feb 23, 1928, that I last saw her alive on Feb 23, 1928, and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH\* was as follows:

Congenital Ateloclasia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 24 Date of

Was there an autopsy? 24

What test confirmed diagnosis?

(Signed) J. C. Gandy, M. D.

, 19 (Address) 1837 Seaford

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Osburn Cemetery

DATE OF BURIAL

Feb 25 1928

20 UNDERTAKER

Lottie Moore 1408 Maryland St



## HEALTH DEPARTMENT—CITY OF BALTIMORE E 30933

30933

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals ST. 12-B WARD)2-FULL NAME Nellie Wright(a) RESIDENCE NO. 2724 Huntington Ave  
(Usual place of abode)Length of residence in city or town where death occurred Unknown yrs. ST. Unknown WARD Unknown  
(If non-resident give city or town and State)

How long in U. S., if of foreign birth? ds. yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18847 AGE Years 44 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Maryland  
(State or country)10 NAME OF FATHER Richard Wright11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Mary Reed13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)Informant Hospital Records  
(Address)

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 14, 19 28, to Feb. 23, 19 28.that I last saw her alive on Feb. 23, 19 28.and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) Unknown yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical and lab.(Signed) Henry C. Smith, M. D.2-24-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cyrus Chapel

20 UNDERTAKER

P. Mackline & Son

DATE OF BURIAL

Feb. 26 1928

ADDRESS

White Hall Md

E 30934

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 30934

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11-25 ST. WARD)2-FULL NAME George Russell(a) RESIDENCE NO. 115 W Hamilton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 Single, Married, Widowed,  
or Divorced, (write the word)Married5a If married, widowed, or divorced,  
HUSBAND of  
(or) WIFE ofDorothea Russell

6 DATE OF BIRTH (month, day, and year)

Oct 4, 1854

7 AGE

72

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.4 19

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of worknone(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Washington D.C.

10 NAME OF FATHER

John J

11 BIRTHPLACE OF FATHER (city or town)

Wash. D.C.

(State or country)

12 MAIDEN NAME OF MOTHER

Lydia

13 BIRTHPLACE OF MOTHER (city or town)

md

(State or country)

Informant

(Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 5, 1927, to 2-21, 1928.that I last saw him alive on 2-21, 1928.and that death occurred, on the date stated above, at 7:09 P. m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Arteriosclerosis  
(duration) ? yrs. mos. ds.18 Where was disease contracted ?  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

Physical Examination(Signed) C. S. Williams, M.D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALBaltimore Am.

DATE OF BURIAL

2-21 1928

20 UNDERTAKER

Wm. Cook

ADDRESS

502 E. North Ave.

316  
E 1130935

## HEALTH DEPARTMENT—CITY OF BALTIMORE

107-003

## CERTIFICATE OF DEATH.

E 30935

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

JOHNS HOPKINS HOSPITAL

ST. 27-43 WARD

## 2-FULL NAME

Charles Ashby

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

7122 Harford Road

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced

HUSBAND of

WIFE of Bertha

6 DATE OF BIRTH (month, day, and year)

1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Travelling Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pa

10 NAME OF FATHER

Dewitt Ashby

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Julia Lush

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

Records

JOHNS HOPKINS HOSPITAL

15

Filed

19

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 19, 1928, to Feb. 23, 1928,

that I last saw him alive on Feb. 23, 1928,

and that death occurred, on the date stated above, at 7<sup>00</sup> A. M.

The CAUSE OF DEATH\* was as follows:

abscess of upper lung over

(duration) 3 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia of chronic type

(duration) yrs. mos. 1 ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Christopher Johnston, M. D.

19 Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Parkwood Cem.

2/25/28, 19

20 UNDERTAKER

ADDRESS

George J. Ruth, 1735 Harford

E 30936

*Lewandowski*  
HEALTH DEPARTMENT—CITY OF BALTIMORE E 30936

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital 16-37* ST. *16-37* WARD)2-FULL NAME *Josephine Lewandowski*(a) RESIDENCE NO. *Balti City Hospital* ST. *16-37* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *25* yrs.

mos.

How long in U. S., if of foreign birth? *25* yrs.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (Write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 1850*

7 AGE

*78* YearsMonths *11*

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Gdansk*  
(State or country)10 NAME OF FATHER *Geo. Lewandowski*11 BIRTHPLACE OF FATHER (city or town) *Poland*  
(State or country)12 MAIDEN NAME OF MOTHER *Antonette Michalaska*13 BIRTHPLACE OF MOTHER (city or town) *Poland*  
(State or country)Informant *Mary Kantorski*  
(Address) *404 W. Main St.*Filed *1928*

19

HAMPSON JONES, M. D.

Registrar *AKA*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-27-1928*

17

I HEREBY CERTIFY, That I attended deceased from *2-22-1928* to *2-27-1928*that I last saw him alive on *2-27-1928*and that death occurred, on the date stated above, at *5:10* m.

The CAUSE OF DEATH\* was as follows:

*Generalized Osteomyelitis  
Chronic Abscesses  
Abscesses*(duration) yrs. mos. *2* ds.CONTRIBUTORY *Chronic Bronchopneumonia*  
(Secondary)(duration) yrs. mos. *1* da.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *Yes* Date of *2-22-28*Was there an autopsy? *No*What test confirmed diagnosis? *Operation*(Signed) *W. H. Jones, M. D.*(Address) *Balti City Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Rosary Cem*DATE OF BURIAL *Feb 27 1928*20 UNDERTAKER *John M. Weber*ADDRESS *1803 Bank St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30937

## CERTIFICATE OF DEATH

E 30937

## 1-PLACE OF DEATH

City of BALTIMORE: (No. **1419** **E** **Clement St.** **24-35** Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME **Genevie Majewska**(a) RESIDENCE NO. **1419** **E** **Clement St.** **St.** **Ward**

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

**Female****White****Single**

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

**Dec. 21 1927**

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

**2****2**

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

**None**

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

**Baltimore Md.**

10 NAME OF FATHER

**Joseph Majewska**

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

**Poland**

12 MAIDEN NAME OF MOTHER

**Catherine Gavrys**

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

**Poland**

14

Informant (Address)

**Joseph Majewska****1419 E Clement St.**

15 Filed

**C. HAMMOND JONES, M. D.**

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

**Feb. 23 1928**

17

HEREBY CERTIFY, That I attended deceased from

**Feb. 21, 1928, to Feb. 23, 1928**that I last saw her alive on **Feb. 23, 1928**and that death occurred, on the date stated above, at **1130 A. M.**

The CAUSE OF DEATH\* was as follows:

**Pneumonia - Pneumonia**(duration) yrs. mos. **3** ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. **1/2** ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? **no** Date ofWas there an autopsy? **no**

What test confirmed diagnosis?

(Signed)

**E. S. Murr, M. D.** (Address) **716 Calver**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

**Holy Rosary Cem Feb. 25 1928**

20 UNDERTAKER

ADDRESS

**John M. Weber 1803**



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30938

E 30938

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Pronounced dead at the

South Baltimore General Hospital

City of BALTIMORE: (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward)

2-FULL NAME

James W. Caulk.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO.

4 W. Cross St.

St. \_\_\_\_\_

Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 9 mos. 14 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male.

White.

Single.

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

8 DATE OF BIRTH (month, day, and year)

May 9, 1861

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

66

9

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.

Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

10 NAME OF FATHER

William Caulk.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Mary Buckner.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia.

14

Informant Mollie Ledley. (sister.)

(Address) 4 W. Cross St.

15

Filed 1925

19

HARRISON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1925

February 23, 1925

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry

(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

2/24 19 23 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Hanover &amp; Cross Sts. Feb. 23, 1923.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30939

CERTIFICATE OF DEATH.

179 E 30939

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 3-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Monteserrato

(a) RESIDENCE NO. 215 S. Eden St

St.          Ward         

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8/1922

7 AGE Years 5 Months 9 Days 15 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

10 NAME OF FATHER Paul Monteserrato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Annetta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Father (Address)

15 Filed C. H. Anderson Registrar

CONORER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Burns- body face & legs. Clothes caught from gas heating stove at 318 S. Eden St.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) J. S. H. Porter M. D. (Coroner)

2/24/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30940

## CERTIFICATE OF DEATH.

E 30940

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST., *4-7* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Joseph C. Walters*

## (a) RESIDENCE NO.

*Huntley, Rap. Co. Va.*

ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. *1* mos. *14* ds.

How long in U. S., if of foreign birth?

yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

*Sarah M. Deary*

## 6 DATE OF BIRTH (month, day, and year)

*Dec 25 1855*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*72**1**30*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Amisville Va*

## 10 NAME OF FATHER

*Charles Walter*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Virginia*

## 12 MAIDEN NAME OF MOTHER

*Could be learned*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Virginia*

## Informant (Address)

*H. G. Deary Hunt Royal Va.*

Filed

19

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/24 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*1/24/28*, 19 \_\_\_\_\_, to *2/24/28*, 19 \_\_\_\_\_,that I last saw him alive on *2/24/28*, 19 \_\_\_\_\_,and that death occurred, on the date stated above, at *2:30* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Pylorus with obstruction*(duration) *25* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

*Myocardial infarction*(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *5* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *clinical*

(Signed)

*J. S. Winkad*, M. D.

, 19 \_\_\_\_\_

(Address)

*Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Hunt Royal Va*

## DATE OF BURIAL

*2/25 1928*

## 20 UNDERTAKER

*W. J. Foston*

## ADDRESS

*Glennburning Md.*

E 30941

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30941

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Bulto. General Hospital* ST. *185* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *2815 W. Kanvale Str* ST. *16-68* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. *—* mos. *—* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 *Single*, Married, Widowed, or Divorced, (write the word)*Female White**Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Halter W. Whitehurst*6 DATE OF BIRTH (month, day, and year) *Sept 5, 1875*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*52**5**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Virginia*

10 NAME OF FATHER

*William Franklin*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*France*

12 MAIDEN NAME OF MOTHER

*Not known*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Not known*Informant  
(Address)*H. W. Whitehurst  
2815 W. Kanvale Str*

Filed

19

*G. HAMMOND JONES, M.D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 24 1928*17 I HEREBY CERTIFY, That I attended deceased from  
*Feb 22*, 1928, to *Feb 24*, 1928,  
that I last saw her alive on *Feb 24*, 1928,and that death occurred, on the date stated above, at *7 P.* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage; (over)*  
*Laceration of scalp due to*  
*Fall.* (duration) yrs. mos. *2* ds.  
CONTRIBUTORY *Pneumonia*  
(Secondary) (duration) yrs. mos. *1* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Benjamin Miller*, M. D., 19 (Address) *2134 W. Baltimore St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Baltimore Va.**Geo. W. Little**Feb 26 1928**Baltimore*



E 30942

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30942

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Baltimore General Hospital*)

## 2-FULL NAME

*Sarah/Helen Johnson*

## (a) RESIDENCE NO.

*Arundel Cove*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

*4*

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*May 31-1918*

## 7 AGE

Years

Months

Days

If LESS than  
1 day..... hrs.  
or..... min.*9**8**< 3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto Md.*

## 10 NAME OF FATHER

*Wm Johnson*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Balto Md.*

## 12 MAIDEN NAME OF MOTHER

*Carrie E. Sharp*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto Md.*

## Informant

(Address)

*Carrie E. Johnson (mother)**Arundel Cove*

## Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb 23 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from  
*Feb 19 1928*, to *Feb 23 1928*,  
that I last saw her alive on *Feb 23 1928*  
and that death occurred, on the date stated above, at *5:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*CONTRIBUTORY  
(Secondary)(duration) yrs. *6* mos. ds.(duration) yrs. *4* mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Autopsy etc.*Signed) *Louis T. Davis*, M. D.(Address) *W. Balto Gen. Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*Mary Beth Church Cemetery Feb 26 1928*

## 20 UNDERTAKER

## ADDRESS

*John F. Denny**715 High St*



E 30943

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30943

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *612 Sallers Road* ST. *27-48* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John N. Gaither*(a) RESIDENCE NO. *612 Sallers Road*

(Usual place of abode)

ST. *27-48* WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Maria D. Gaither*

6 DATE OF BIRTH (month, day, and year)

*Mar. 22 1854*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

*73**74**11**2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Retired Mariner*

9 BIRTHPLACE (city or town) (State or country)

*A.A. Co*

10 NAME OF FATHER

*Yachel N. Gaither*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*A.A. Co*

12 MAIDEN NAME OF MOTHER

*Margaret Robinson*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ind*

14 Informant (Address)

*Reed Gaither 612 Sallers Rd. Gorman*

15 Filed

19

*1928* *C. HAMPSON, JR., M.D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 24 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 24 1928*, to *Feb 24 1928*that I last saw him alive on *Feb 23 1928*and that death occurred, on the date stated above, at *1:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*(duration) yrs. mos. *1 1/2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *C. H. Duval*, M. D.(Address) *1817 N. Teulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Olivet Cem.**Feb 25 1928*

20 UNDERTAKER

ADDRESS

*John F. Denny**75 Light St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30944

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

Pronounced dead at the  
City of BALTIMORE: (No. South Baltimore General Hospital Ward)(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## 2-FULL NAME

Clay Duvall Perkins.

## (a) RESIDENCE NO.

Springfield, Md.

St. 24-33 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male.

White.

Widower.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Do not know.

## 6 DATE OF BIRTH (month, day, and year)

July 23, 1860

## 7 AGE

## Years

## Months

## Days

IF LESS than  
1 day.....hrs.  
or.....min.

67

7

0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....

Farmer.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town).....

(State or country)

Springfield, Md.

## 10 NAME OF FATHER

James T. Perkins.

## 11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Maryland.

## 12 MAIDEN NAME OF MOTHER

Susan M. Travers.

## 13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Maryland.

## 14

Informant  
(Address)Edward A. Perkins. (brother,  
Springfield, Md.

## 15

Filed....., 19

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1923

February 23, 1923

## 17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry

Inquest, au-  
topsy or inquiry.

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Internal injuries

Caught under an overturned automobile.

probably accidental.

investigation conducted by Prince

George Co. authorities.

## CONTRIBUTORY

(Secondary)

(Signed)

Otto M. Reinhardt

(Coroner)

2/24 19 28 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death.....

yrs.....

mos.....

ds. In the

State.....

yrs.....

mos.....

ds.

Where was disease contracted, if not at place of death?

Crain Highway nr. Upper Marlboro 2/22/23

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

## Date of Burial

Springfield, Md. via Auto

Feb 26 1923

## 20 UNDERTAKER

## ADDRESS

John F. Denny

715 Light St

E 30945

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30945

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *457 St. Mary St.* ST. *11-24* WARD)2-FULL NAME *Bertie Jones*(a) RESIDENCE NO. *457 St. Mary St.* ST. *11-24* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *41* yrs. mos. ds.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**Colored**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown 1886*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*41*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laundress*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Moses Jones*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Virginia*

12 MAIDEN NAME OF MOTHER

*Rachel Fort*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Maryland*

14

Informant (Address)

*Edith Jones 457 St. Mary Street*

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*July 23 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*June 23, 1927, to July 22, 1928*

that I last saw him alive on

*July 22, 1928*

and that death occurred, on the date stated above, at

*930 p.m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis  
Mitral Regurgitation*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*Home*

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Examination*

(Signed)

*Chas. J. Claiborne, M. D.*1872<sup>4</sup>, 1928 (Address)*1501 McCall St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Auburn Cem.**2/25 1928*

20 UNDERTAKER

ADDRESS

*John H. Jordan**1027 Grand Hill*

E 30946

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30946

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST., 100 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Callum(a) RESIDENCE NO. 545 Calum ST., 14-20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male ColoredSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7618-5-2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore  
Maryland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Records

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/1928

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 6, 1918, to Dec. 22, 1928that I last saw him alive on Dec. 22, 1928and that death occurred, on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH\* was as follows:

Scurvy pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Special(Signed) C. J. Jones, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

My Calum Bur. Feb 24, 1928

20 UNDERTAKER

ADDRESS

James E. Carter 916  
Oa ai

E 30947

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30947

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Webster ST.,WARD) 24-332-FULL NAME Ellavania Dempster(a) RESIDENCE NO. 1715 Webster

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred 73 yrs.

mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Dempster6 DATE OF BIRTH (month, day, and year) Dec 11, 1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73212

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER John F. Dempster11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore12 MAIDEN NAME OF MOTHER Mary J. Tuttle13 BIRTHPLACE OF MOTHER (city or town) (State or country) BaltimoreInformant (Address) Mr. Geo. King Jr.1715 Webster St.Filed 25, 1928

C. HAMPSON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23, 1928

17

I HEREBY CERTIFY That I attended deceased from July 4, 1924, to Feb 23, 1928 that I last saw him alive on Feb 23, 1928 and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of BreastCONTRIBUTORY (Secondary) Exhaustion

(duration)

yrs.

mos.

ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Campbell

7/24, 1924

(Address) 1644 Hanover St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park

DATE OF BURIAL

Feb 25, 192820 UNDERTAKER John Ullrich

ADDRESS

2008 Orleans



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30948

## CERTIFICATE OF DEATH

E 30948

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2319 N. Charles St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine C. Hoopes(a) RESIDENCE NO. 2319 N. Charles St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Los. T. Hoopes

6 DATE OF BIRTH (month, day, and year)

Sept. 2, 1860

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

67 5 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto. Md

10 NAME OF FATHER

John O. Mahon

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Ethel Mahon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

Mrs. Fannie M. Spanner  
2319 N. Charles St.

15

Filed

10

RPH

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 1928

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 26, 1927, to Feb. 23, 1928.that I last saw him alive on Feb. 23, 1928.and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma R. Breast.(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY

(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. F. Robinson, M. D., 19 (Address) 836 Park Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Stone Chapel, Parkville Feb. 23, 1928

20 UNDERTAKER

ADDRESS

John C. Mitchell Sons, 1900 Lataw Plac

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30949

## CERTIFICATE OF DEATH

46 E 30949

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *258 St. Paul* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *258 St. Paul* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 Color or Race

W

5 Single, ☒ Married, Widowed, or Divorced, (write the word)5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *A. Spina*

6 DATE OF BIRTH (month, day, and year)

7/5/1886

7 AGE

Years

Months

Days

41

5

7

IF LESS than 1 day...hrs. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Italy*

10 NAME OF FATHER

*V. Barbagallo*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Italy*

12 MAIDEN NAME OF MOTHER

*Josephine Ann*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Italy*

14

Informant (Address)

*Hosp. Records*

15 Filed

19

C. HAMMON JONES, M. D.

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7/27/28

17

I HEREBY CERTIFY, That I attended deceased from

7/17/28 to 7/27/28

that I last saw him alive on 7/24/28

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Epithelioma Cervix Uteri*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

*Acute Myocarditis**Acute Myocarditis* (duration) yrs. mos. ds.

18 Where was disease contracted

*Home*

if not at place of death?

Did an operation precede death?

7/20/28

Was there an autopsy?

126

What test confirmed diagnosis?

(Signed)

*Chas. W. Jones, M. D.*

(Address)

State the Disease Causing Death, or in deaths from Violent Causes, state the Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Holy Redeemer*

Date of Burial

Feb 27 1928

20 UNDERTAKER

*Frank V. Pipitone*

ADDRESS

*2513 Baltimore*

E 30950

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30950

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 E 25th ST., 9-46 WARD)2-FULL NAME Lillie M. Melvin(a) RESIDENCE NO. 1624 E. 25th

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of John H. Melvin (or) WIFE of6 DATE OF BIRTH (month, day, and year) April 31-18707 AGE Years 57 Months 9 Days 22 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Freedom (State or country) Pa.10 NAME OF FATHER George R. Decker11 BIRTHPLACE OF FATHER (city or town) York Co (State or country) Pa.12 MAIDEN NAME OF MOTHER Sydia Hunt13 BIRTHPLACE OF MOTHER (city or town) York Co (State or country) Pa.14 Informant Clarence J. Melvin (Address) 1601 Northwood Ave15 Filed 1928, 19 60 Registrar John H. Melvin

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23- 19 28

17

I HEREBY CERTIFY, That I attended deceased from July 1, 19 27, to Feb. 23-, 19 28, that I last saw her alive on Feb. 22, 19 28,and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Papilloma of Cervix(duration) 2 yrs. mos. ds.CONTRIBUTORY Melancholic Carcinoma of

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ☒ if not at place of death?Did an operation precede death? yes - Date of Oct 25-1927Was there an autopsy? ☒What test confirmed diagnosis microscopic exam -(Signed) Robert H. Henshaw, M. D.F44, 1928 (Address) 211 V. Henshaw

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Freedom, Pa.Feb. 26 19 28

20 UNDERTAKER

ADDRESS

Hartman's Monuments, Red Lion, Md.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30951

105 E 30951

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced. (write the word)

Female White

Widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Charles Newton Merritt

6 DATE OF BIRTH (month, day, and year)

Feb. 27 1856

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

71

11

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Balto. Co  
Md.

10 NAME OF FATHER

Joshua Lynch

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Rogers

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Balto.  
Md.Informant  
(Address)Mrs. Geo. L. Gwalt  
2945 St. Paul St.

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 23, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 2<sup>nd</sup>, 1928 to Feb. 23<sup>rd</sup>, 1928.  
that I last saw him alive on Feb. 23<sup>rd</sup>, 1928.

and that death occurred, on the date stated above, at 4:40 A.M.

The CAUSE OF DEATH\* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Bronchial Asthma  
2 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? usual

(Signed) G. Lathrop Ewell, M. D.

2/24, 1928 (Address) 2945 St. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Arund Ridge

Feb. 25, 1928

20 UNDERTAKER

ADDRESS

W. J. Tickner &amp; Sons

N. &amp; Pa.







## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30953

## CERTIFICATE OF DEATH.

E 30953

1-PLACE OF DEATH Pronounced dead at  
City of BALTIMORE: (No. St. Joseph Hospital 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Joanna Stansbury(a) RESIDENCE NO. 932 N. Central Ave St.          Ward         

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Inf. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced  
HUSBAND of unknown Stansbury  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21/1901

7 AGE Years 26 23 Months 7 Days 2 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland  
(State or country)

10 NAME OF FATHER Samuel H. Eckard11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Florence A. Mathias13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)

14 Informant Mother  
(Address)

15 Filed 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Hemorrhagedue to pistol shot wound of liver. Homicide

(duration) .....yrs. ....mos. ....ds.  
CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.  
(Signed) [Signature] M. D.  
(Coroner)

2/25/28 Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.  
Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Pleasant Valley, Md. Feb 27 1928

20 UNDERTAKER

ADDRESS

Joseph Syfer 1600 W. North Ave

E270954

## HEALTH DEPARTMENT—CITY OF BALTIMORE 30954

## CERTIFICATE OF DEATH. 49

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

JOHN'S HOPKINS HOSPITAL

ST.

WARD

## 2-FULL NAME

Vincent G. Abreu

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Malecon 317

ST.

WARD

Havana Cuba

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Lorise

6 DATE OF BIRTH (month, day, and year)

7-22-65

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

64

7

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Sugar Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Cuba

10 NAME OF FATHER

Vincent G. Abreu

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Cuba

12 MAIDEN NAME OF MOTHER

Lorise Silva

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Cuba

14

Informant  
(Address)

Records -

15

Filed

19

Register

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 24 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 7 1928 to Feb 24 1928

that I last saw him live on Feb 24 1928

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH\* was as follows:

Hypernephroma, left kidney

(duration) 1 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Havana, Cuba

Did an operation precede death?

yes Date of Feb 24 1928

Was there an autopsy?

yes

What test confirmed diagnosis?

(Signed)

James M. D.

19 (Address)

Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Havana Cuba

Feb 26 1928

20 UNDERTAKER

ADDRESS

Edm O'Connell Sons Inc

Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

8114  
24<sup>th</sup> 30955

117 E 30955

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E 30955)

## 2-FULL NAME

DER FOOLE (Der Roy Yuen)

## (a) RESIDENCE NO.

2339 E. Monument St.

(Usual place of abode)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Yellow

## 5 Single, Married, Widowed, or Divorced (write the word)

?

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

?

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

52

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Laudy man

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

China

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

Ruehl

## 15

Filed

1928

Registered

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 23 1928

## 17

I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1928, to Feb. 23, 1928, that I last saw him alive on Feb. 23, 1928,

and that death occurred, on the date stated above, at 4:30 p. m.

## The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

## CONTRIBUTORY (Secondary)

Registered appendix - Generalized peritonitis

(duration) yrs. mos. 21 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 4, 1928

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

R. Y. Rumble

M. D.

Feb 23 1928 Address

Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Burial

Baltimore Cemetery

Feb 27 1928

## 20 UNDERTAKER

## ADDRESS

John Mitchell 1900 E. ...

E 30956

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30956

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 311 Dolphine St., 11-24 Ward)2-FULL NAME Lelia Daisy West(a) RESIDENCE NO. 311 Dolphine

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or race

5 Single, Married, Widowed, or Divorced, (write the word)

Female white Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert E. West6 DATE OF BIRTH (month, day, and year) Aug 11, 1885

7 AGE

Years

Months

Days

IF LESS than 1 day....hrs. or....min.

42 6 12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Home duties

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Benson Blake Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Jennie Kyle Md.

14

Informant (Address)

Albert E. West 311 Dolphine St.

15

Filed..... 19

RPM

Registered

REGISTERED NO. 167-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)hereon and from the evidence obtained by said Inquiry and that said deceased came to death on the day stated above her

The CAUSE OF DEATH was as follows:

Gas Poisoning Ill-

CONTRIBUTORY (Secondary)

Asphyxia (duration) yrs. mos. ds.Feb 24/28 (Signed) G. H. Blake (Coroner) M. D.(Address) 1436 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Druid Ridge Feb 25 1928

20 UNDERTAKER

ADDRESS

John Mitchell, Inc 1900 Eutaw Place



E 30957

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 30957

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 222 So. Ann

St. 2-4 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOHN BARSZCZ,

(a) RESIDENCE NO. 222 So. Ann

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds.

St. Ward

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? 44 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Anna Barszcz,

6 DATE OF BIRTH (month, day, and year)

July -- 1871

7 AGE

Years

Months

Days

56

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Day laborer,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Poland,

10 NAME OF FATHER

Jacob Barszcz,

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Poland,

12 MAIDEN NAME OF MOTHER

Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland,

14

Informant (Address)

Mrs. Anna Barszcz, (Wife)

222 So. Ann Street

15

1920

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Feb. 24, 1928, that I last saw him alive on Feb. 24, 1928, and that death occurred, on the date stated above, at 2:20 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilatation

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. A. S.

(Signed)

19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Stanislaus,

Feb. 27, 1928

20 UNDERTAKER

ADDRESS

M. F. Sadowski,

405 E. Anne St



E 30958

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30958

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2157 W. Fairmount St., 20th WARD)

## 2-FULL NAME

(a) RESIDENCE No. 2157 W. Fairmount St., 20th

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 10 mos. 16 ds.

REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Feb, 22, 1928, to Feb, 23, 1928, that I last saw him alive on Feb, 23, 1928, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Gastric Carcinoma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 70 Date of 1927

Was there an autopsy? on

What test confirmed diagnosis?

(Signed) Abraham Shapiro, M. D., 19 (Address) 2029 W. Pratt Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 30959

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30959

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3403 Piedmont Ave ST., 15-161 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Rose Peiser

## (a) RESIDENCE NO.

3403 Piedmont Ave ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Harry Peiser

## 6 DATE OF BIRTH (month, day, and year)

Mar 24 - 1856

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

71 11 —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ireland

## 10 NAME OF FATHER

Harry Meekhan

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Catherine O'Farrell

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14

Informant (Address)

Annie Peiser 3403 Piedmont Ave

## 15

Filed 2, 19 28Registrar RRR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 24<sup>th</sup> 1928

## 17

I HEREBY CERTIFY, That I attended deceased from Feb 7, 1928, to Feb 24, 1928,that I last saw him alive on Feb 24, 1928and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhagemyocarditis(duration) yrs. mos. about 14 ds.

## CONTRIBUTORY (Secondary)

arteriosclerosis

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Walter S. Hubert, M. D.(Address) 2220 Garrison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Green Ridge Cemetery 2/27 1928

## 20 UNDERTAKER

## ADDRESS

Chas. F. Wane & Son 118 West Royal Ave

E 30960

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30960

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *6314 Brook Ave.* ST. *27* WARD *H 2*)2-FULL NAME *Margaret M. Kelly*(a) RESIDENCE NO. *6314 Brook Ave.* ST. *27* WARD *H 2*

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *John Kelly*6 DATE OF BIRTH (month, day, and year) *Jan 6, 1857*

7 AGE

Years *71*Months *1*Days *18*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Richmond Va* (State or country)10 NAME OF FATHER *James Mahoney*11 BIRTHPLACE OF FATHER (city or town) *Richmond Va* (State or country)12 MAIDEN NAME OF MOTHER *Margaret Price*13 BIRTHPLACE OF MOTHER (city or town) *Richmond Va* (State or country)

14

Informant *Wm H. McLean*(Address) *6314 Brook Ave*

15

Filed *Feb 27*, 19 *1928*Registrar *RRH*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 24 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 17*, 1928, to *Feb. 24*, 1928, that I last saw *her* alive on *Feb. 23*, 1928,and that death occurred, on the date stated above, at *7 A. M.*

The CAUSE OF DEATH\* was as follows:

*Bronchial Pneumonia*(duration) yrs. mos. ds. *8*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Physicist signs*(Signed) *James E. Mahoney*

M. D.

(Address) *700 W. N. Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *New Cathedral*DATE OF BURIAL *Feb 27 1928*20 UNDERTAKER *George J. Smith*ADDRESS *153 L**Hollins*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30961

E 30961

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Md General Hospital

REGISTERED NO.

City of BALTIMORE: (No.)

Madison &amp; Lucas Sts. 56-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henrietta Krauss

(a) RESIDENCE NO.

2722 Winchester St.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

4 yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Louis L. Krauss

6 DATE OF BIRTH (month, day, and year)

6-9-1863

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

64 8 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

Self

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

Konrad Gorkel

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Ella Red Videman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Hospital Room

15 Filed

19

1928

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2-24-28

17

1 HEREBY CERTIFY, That I attended deceased from

2-9-28, 19, to 2-24-28

that I last saw him alive on 2-24-28

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Cholelithiasis Chole  
cystitis & Stomach  
congestion

(duration) 20 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Arteriosclerosis &amp; Slow cardiac impulse

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of 2-11-28

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park

Feb 27 1928

20 UNDERTAKER

George J. Smith

ADDRESS 1532

Hollins







## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30963

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE

(No.)

St.

Ward

## 2-FULL NAME

(a) RESIDENCE NO.

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15 Filed

19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY That I took charge of the

remains described above, held an Inquest, Autopsy or inquiry.)

Thereon and from the evidence obtained by said Inquest, Autopsy or inquiry.)

I had that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Asphyxia Liv  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)L.N. G.C. Spade  
(Signature) (Coroner) M. D.

24/20 (Address) 14361 Bray

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

Commissioner Health

FEB 24 1928

THE MORGUE

very important. See instructions on back of certificate.

Exact statement of OCCUPATION is

E 30964

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30964

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST., 19-28 WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

2-FULL NAME J. Edmund D. Dittler(a) RESIDENCE NO. 1411 Dwellers  
(Usual place of abode)Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds.

ST., \_\_\_\_\_ WARD \_\_\_\_\_  
 (If non-resident give city or town and State)  
 How long in U. S., if of foreign birth? 2 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed,  
 or Divorced, (write the word) ?

5a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_  
 If LESS than  
 1 day, \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work none(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Germany10 NAME OF FATHER John Dittler11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany12 MAIDEN NAME OF MOTHER Married13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany14 Informant (Address) Records15 Filed 1928 OKH Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/1928

17 I HEREBY CERTIFY, That I attended deceased from  
Dec 2, 1928, to Dec 21, 1928  
 that I last saw him alive on Dec 21, 1928  
 and that death occurred, on the date stated above, at 10:10 A. M.  
 The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic acute  
arteriosclerosis  
hypertension  
 (duration) \_\_\_\_\_ yrs. 20 mos. 0 ds.

CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted  
if not at place of death? ?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? General & Sub.(Signed) C. Edmund Dittler, M. D.  
, 19 \_\_\_\_\_ (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL  
MOVING Dec 2/28  
1136  
 20 UNDERTAKER 1136

E 30965

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 16 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

1928

G. HAMMOND JONES, M. D.  
Registrar

E 30965

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 23, 1928, to

that I last saw him alive on Feb. 23, 1928,

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH\* was as follows:

Sobar pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 3 hrs.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? Permission granted.

What test confirmed diagnosis?

(Signed)

J. S. Bennett

M. D.

Feb 27, 1928 (address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health.

E 30966

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30966

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital* 26-37)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William Doake*(a) RESIDENCE NO. *Cumland md.*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male white**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*54*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*John M Doake*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Mary Bell*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*md.*

14

Informant (Address)

15

Filed

G. HAMMOND JONES, M. D.  
2200 DR A Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*2-23 1928*

17

I HEREBY CERTIFY, That I attended deceased from *2-11-*, 19*28*, to *2-23*, 19*28*that I last saw him alive on *2-23*, 19*28*and that death occurred, on the date stated above, at *3:15* m.

The CAUSE OF DEATH\* was as follows

*Cerebral Stenosis*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*Same*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis

*Autopsy*

(Signed)

*Blanchard* M. D.

, 19 (Address)

*Balti City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Continental Health.

ADDRESS

FEB 25 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

30967

30967

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2726 Prospect, St. 16-68 Ward)

## 2-FULL NAME

Albert P. Rommel

## (a) RESIDENCE NO.

2726 Prospect

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 29 - 1928

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.525

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....Kindergarten(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Md

## 10 NAME OF FATHER

Albert P. Rommel

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Elizabeth M. Lawrence

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

## 14

Informant  
(Address)Albert P. Rommel  
2726 Prospect St

## 15 Filed....., 19

RKH

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 4 1928

## 17

I HEREBY CERTIFY that I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)Inquest and from the evidence obtained by said  
Inquest, autopsy or inquiry, and that said deceased came to death  
on the day stated above.

## The CAUSE OF DEATH\* was as follows:

acc. Burns  
2nd & 3rd DegreeCONTRIBUTORY  
(Secondary)Toxemia  
Feb 24/28 (duration) 2 hrs yrs. mos. ds.  
G. B. Blades (Coroner) M. D.  
143 N. E. Way (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Western Cemetery Feb 27 1928  
20 UNDERTAKER ADDRESS 723  
Edmond W. L. J. 142



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30968

## CERTIFICATE OF DEATH.

E 30968

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St. 4-33 Ward 4-33)2-FULL NAME John R. Davis(a) RESIDENCE NO. 1423 Riverside St. 4 Ward 4

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Lillie Davis  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb 4-18937 AGE Years Months Days IF LESS than  
34 4 19 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman(b) General nature of industry, business, or establishment in which employed (or employer) Pr & C - 073(c) Name of employer Rail Road

## 9 BIRTHPLACE (city or town)

(State or country) Ind10 NAME OF FATHER John H. Davis11 BIRTHPLACE OF FATHER (city or town) Argonia  
(State or country)12 MAIDEN NAME OF MOTHER Rodriguez13 BIRTHPLACE OF MOTHER (city or town) Argonia  
(State or country)14 Informant (Address) John R. Davis  
1423 Riverside15 Filed 1925 Registrar W. H. BullyREGISTERED NO. 188-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:  
Caught between two box cars.  
Fracture Pelvis & Internal  
Hemorrhage (duration) .....yrs. ....mos. ....ds.CONTRIBUTORY (Secondary) Fracture Pelvis & Internal Hemorrhage (duration) .....yrs. ....mos. ....ds.  
(Signed) John H. Davis M. D.  
(Coroner)25, 1925 (Address) 3632 Polaris

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood Date of Burial Feb 26 192520 UNDERTAKER W. H. Bully ADDRESS 128 E. Hart Ave

PHYSICIANS SHOULD SIGN CASE  
E  
very important. See instructions on back of certificates.

Spec. -7-17-26-A Co.-200 Bks.

HEALTH DEPARTMENT-CITY OF BALTIMORE

30969

CERTIFICATE OF DEATH

10-002  
E 30969  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Sydenham Hospital* 7-10 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Leah Wine*

(a) RESIDENCE NO. *508 N. Collington Ave* St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female*

*White*

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan 27, 1927*

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

*1*

*0*

*28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

*Baltimore*

(State or country)

*Maryland*

10 NAME OF FATHER

*Joseph Wine*

11 BIRTHPLACE OF FATHER (City or town)

*Baltimore*

(State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Leah Lumphkin*

13 BIRTHPLACE OF MOTHER (city or town)

*Baltimore*

(State or country)

*Maryland*

14

Informant

*Mrs. Leah Wine*

(Address)

*508 N. Collington Ave.*

15 Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*Feb. 24, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 23, 1928, to Feb. 24, 1928,*

that I last saw her alive on

*Feb. 24, 1928,*

and that death occurred, on the date stated above, at

*5:40 p.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria - Toxic*

*Pharyngeal & Laryngeal*

(duration)

Yrs.

Mos.

Da. *5*

CONTRIBUTORY

(Secondary)

(duration)

Yrs.

Mos.

Da. *7*

18 Where was disease contracted

If not at place of death?

*At home*

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Bacteriological*

(Signed)

*J. L. Levin*

M. D.

Feb 25 1928

(Address)

*Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Oak Lawn Cemetery*

*Feb 25, 1928*

20 UNDERTAKER

ADDRESS

*Mary M. Wadfield*

*501 E. 32nd St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30970

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. ST. 14 WARD 70)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 23, 1928, to Feb. 24, 1928,  
that I last saw him alive on Feb. 24, 1928,

and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH\* was as follows:

Intracranial Injury  
C. Haemorrhage (Cerebral)CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of Feb. 23/28

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 30971

## CERTIFICATE OF DEATH

90 E 30971

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 205 Henderson Road 12-48 Ward)2-FULL NAME Thomas Goodwillie

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 205 Henderson Road St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteMarried

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMary Barnett Goodwillie

6 DATE OF BIRTH (month, day, and year)

Oct 20 1839

7 AGE

88 Years

Months

4

Days

4IF LESS than  
1 day.....hrs.  
or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Oil business

(c) Name of employer

Standard Oil Co.

9 BIRTHPLACE (city or town)

Poland

(State or country)

Ohio

10 NAME OF FATHER

David Goodwillie

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Barnet, H.

12 MAIDEN NAME OF MOTHER

Frances Amiel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant  
(Address)Mary C. Goodwillie  
205 Henderson Road

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) II, 24 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 12, 1928, to Feb. 24, 1928.that I last saw him alive on Feb. 24, 1928.and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH\* was as follows:

Advanced Myocarditis (years)Bronchitis(duration) yrs. mos. 14 ds.

CONTRIBUTORY

(Secondary)

Pneumonia(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Physical signs & symptoms(Signed) Frank R. Smith, M. D.1925, 1928 (Address) 927 N. Calvert St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Cleveland OhioFeb 26 1928

20 UNDERTAKER

ADDRESS  
m. C. C. C.  
Orchard StHenry H. Jenkins Sons Co

very important. See instructions on back of certificates. Exact statement of OCCUPATION is



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30972

## CERTIFICATE OF DEATH.

E 30972

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 320 Worsley St. 12-50 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 320 Worsley St. 12 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 Color or Race C. 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Robert Berry

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than  
about 45 I day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) Md.  
(State or country)10 NAME OF FATHER Mike Thomas11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Md.12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Robert Berry  
(Address) 320 Worsley St.15 Filed....., 19 25 Registrar K. J. K.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/22 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy  
(duration) yrs. mos. ds.CONTRIBUTORY (Secondary)  
(duration) yrs. mos. ds.  
(Signed) John H. H. H. M. D.  
(Coroner)9/25, 1928 (Address) 3632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Date of Burial Feb 24 192820 UNDERTAKER Mrs. R. A. Abbott ADDRESS 1123

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is



Spec.—1-12-23—M&T—500 Bks.

Exact statement of OCCUPA-  
tion is very important. See instructions on back of certificates.

*Duffin*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30973

CERTIFICATE OF DEATH.

129 E 30973

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *379 Hoffman* ST. *11-24* WARD)

2-FULL NAME *Bro. W. Duffin*

(a) RESIDENCE NO. *379 Hoffman* ST. *11-24* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Cauc* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary Duffin*

6 DATE OF BIRTH (month, day, and year) *1867-*

7 AGE *57* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work...

*Batter 070*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Proctor & Knolly*

(c) Name of employer

*Dr. Watson*

9 BIRTHPLACE (city or town) (State or country)

*Md.*

10 NAME OF FATHER *Chas. Duffin*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

12 MAIDEN NAME OF MOTHER *Widow*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

14 Informant *Chas. Duffin* (Address) *1704 B. Ave. St.*

15 Filed *19* Registrar *R.H. Ellert*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/24/28*

17 I HEREBY CERTIFY, That I attended deceased from *4/18/28* to *4/24/28*, 19*28* that I last saw him alive on *4/24/28*, 19*28* and that death occurred, on the date stated above, at *345 Wm* The CAUSE OF DEATH\* was as follows:

*Acute Nephritis*

(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary) *hemip*

(duration) *1* yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death? *no*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Penicillin*

(Signed) *H. Lee Ellis*, M. D.

(Address) *524 Wm*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St. Lukes* DATE OF BURIAL *2/26/28*

20 UNDERTAKER *Mrs. R. H. Ellert* ADDRESS *1704 B. Ave. St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30974

## CERTIFICATE OF DEATH.

128 E 30974

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2435 Eutaw Place

13-59 Ward)

2-FULL NAME Jacob Voloshen

(a) RESIDENCE NO. 2435 Eutaw Place

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Dora Voloshen

6 DATE OF BIRTH (month, day, and year)

June First 1898

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

29

30

8

24

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Lawyer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore City MD

10 NAME OF FATHER

Benj Voloshen

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Sarah Rossman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant Nathan Voloshen  
(Address) 2435 Eutaw Place

15 Filed..... 19

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/25 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

Inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Acute Nephritis  
Internal Hemorrhage

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Intestinal Ulcers

(duration)

yrs.

mos.

ds.

(Signed)

(Coroner)

M. D.

2/25, 1928 (Address)

3632 Roland

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

In the

of death.....yrs.,.....mos.,.....ds. State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Hebrew Freindship Cem

2/26 1928

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E Balto St

Very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30975

E 30975

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Sinia Hospital)St. 13-57Ward 52-FULL NAME Louis Friedenber(a) RESIDENCE NO. 2264 Woodberry Ave

St. \_\_\_\_\_

Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 36 yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Rose Friedenber

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

57

"

"

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

paperhanger

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Mendel Friedenber

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant Rose Friedenber(Address) 2264 Woodberry Ave

15 Filed....., 19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.)and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) .....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Signed) John E. Palmer

(Coroner)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Hebrew Southern AveFeb 26 192820 UNDERTAKER Jack Lewis 1439 E Balt St ADDRESS

Very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30976

## CERTIFICATE OF DEATH.

E 30976

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 E. Fairmount Ave. 9th WARD)

## 2-FULL NAME

Pessie Karasik

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1819 E. Fairmount Ave.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W- 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of  
or WIFE of

Aaron Karasik

6 DATE OF BIRTH (month, day, and year) unknown7 AGE Years Months Days If LESS than 1 day, hrs. or min. 73

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant  
(Address)Ellis Karasik  
1540 E. Pratt St.

15

Filed

19

RLLK

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1926 to Feb. 24 1928, that I last saw her alive on Feb. 24 1928, and that death occurred, on the date stated above, at 1203 A. M.

The CAUSE OF DEATH\* was as follows:

General Arterio Sclerosis

(duration)

Chronic

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical finding

(Signed)

M. H. Curran, M. D.

45, 1928 (Address)

3 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

ADDRESS

Hebrew Cemetery  
John Lewis 1439 E. Pratt St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30977

## CERTIFICATE OF DEATH.

92E 30977

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sinai Hospital*)2. FULL NAME *Louis M Sherry*(a) RESIDENCE No. *1102 Light St.*

(Usual place of abode)

Length of residence in city or town where death occurred *48* yrs. mos.

ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Ann Sherry* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *April 4 1876*7 AGE Years *51* Months *9* Days *21* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Shoemaker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Bernard Sherry*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Reoru*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*14 Informant *Louis Patts*(Address) *1102 Light St.*15 Filed *19*Registrar *R. W. H.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-24 1928*17 I HEREBY CERTIFY, That I attended deceased from *2-13*, 19 *28*, to *2-24*, 19 *28*.that I last saw him alive on *2-24*, 19 *28*and that death occurred, on the date stated above, at *420 P. M.*

The CAUSE OF DEATH\* was as follows:

*Mesenteric Thrombosis.*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *2/13/28*Was there an autopsy? *No* *Resection of*What test confirmed diagnosis? *Operation - Intestines.*(Signed) *Harry Weintraub*, M. D., 19 (Address) *Sinai Hospital.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Hebrew Burial Society* *2/26 1928*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Baltimore*

See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

21137.5  
E 30978

## CERTIFICATE OF DEATH.

E 30978

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 11 HOPKINS HOSPITAL ST., 7-4 WARD)

## 2-FULL NAME

Thelma Bowman

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Black

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Wash. D. C.

## 10 NAME OF FATHER

Sidney Bowman

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md -

## 12 MAIDEN NAME OF MOTHER

Ethyl Chase

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md -

## 14

Informant  
(Address)

Records -

## 15

Filed

19

RLL

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 - 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 21, 1928, to Feb. 25, 1928,  
that I last saw her alive on Feb. 25, 1928,  
and that death occurred, on the date stated above, at 10:40 a.m.

The CAUSE OF DEATH\* was as follows:

Brain Tumor - Glioma  
(Benign) Right Hemisphere

(duration) ? yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death? Yes Date of Feb. 24, 1928

Was there an autopsy? No.

What test confirmed diagnosis? Clinical &amp; operative

(Signed) F. D. Coman, M. D.

Address John Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Washington, D.C.

## DATE OF BURIAL

2-29-1928

## 20 UNDERTAKER

Geo. Snowden Co

## ADDRESS

Rockville, Md.

See instructions on back of certificates.

See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Hks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30979

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Balt. Gen. Hosp.* ST. *16-67* WARD)

### 2-FULL NAME

(a) RESIDENCE NO. *West Balt. Gen. Hosp.* ST. *16-67* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*

4 COLOR OR RACE *White*

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 10, 1928*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*15*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore, Maryland.*

10 NAME OF FATHER *Earl Jones*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Anna (Hendel) Co. Maryland.*

12 MAIDEN NAME OF MOTHER *Edith M. Elphart*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore, Maryland.*

14

Informant *Earl Jones*

(Address) *2900 Mosher Street*

15

Filed

19

Registrar *R. H. H.*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 15, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 10*, 1928, to *Feb. 25*, 1928.

that I last saw him alive on *Feb. 25*, 1928.

and that death occurred, on the date stated above, at *11:45 A. M.*

The CAUSE OF DEATH\* was as follows:

*Spontaneous jaundice*

CONTRIBUTORY (Secondary) *Chronic infection of heart* (duration) yrs. mos. *2* ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Louis T. Tave*

(Address) *10-12 West Gen. Hosp.*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Asbury Cemetery, Annapolis, Maryland*

*Feb. 26, 1928.*

20 UNDERTAKER

ADDRESS

*George J. Smith*

*1532 Hollins*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

KE 30980

## CERTIFICATE OF DEATH.

90 E 30980

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 N. Fayette

ST. 18-76 WARD)

## 2-FULL NAME

William Francis Minnick

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

802 N. Fayette

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

63 yrs. 6 mos. 18 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma A. Minnick

## 6 DATE OF BIRTH (month, day, and year)

Aug 6th 1864

## 7 AGE

Years

Months

Days

63

6

18

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Insurance

## (b) General nature of industry, business, or establishment in which employed (or employer)

Agent

## (c) Name of employer

J. Henry Stranbridge

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

William Frank Minnick

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't know

## 12 MAIDEN NAME OF MOTHER

Maria Brendel

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hagerstown Md

## 14

Informant (Address)

Emma A. Minnick 802 N. Fayette St

## 15

Filed 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 24th 1928

## 17

I HEREBY CERTIFY, That I attended deceased from Sept 1927, to Feb 23 1928,

that I last saw him alive on Feb 23 1928,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH\* was as follows:

Coronary Atherosclerosis. Myocarditis. (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Acute Cardiac Dilatation (duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

## What test confirmed diagnosis?

(Signed)

Harry Glassman M. D.

(Address)

2687 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Western Cemetery

2/27/28

## 20 UNDERTAKER

## ADDRESS

Geo. Weber &amp; Son 2503 Edmondson Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 30981  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

90 E 30981

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 505 Colvin ST. 5-8 WARD)

2-FULL NAME Lena Kline

(a) RESIDENCE NO. 505 Colvin

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 15 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth 2 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

8 LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town, State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town, State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 21, 1928 to Feb 24, 1928.

that I last saw him alive on Feb 23, 1928.

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

Submucous Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Very important. See instructions on back of certificates. Exact statement of OCCUPA-



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30982

## CERTIFICATE OF DEATH.

E 30982

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Cranford ST. 9-47 WARD)2-FULL NAME Allen Rogers Andrews(a) RESIDENCE No. 610 Cranford ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19-1926

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cloned

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Emis J. Andrews11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Elizabeth C. Rogers13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14

Informant (Address) Elizabeth Andrews  
610 Cranford St.

15

Filed 1928 19Registrar R. H. H. H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 22<sup>nd</sup> 1928 to Feb 25<sup>th</sup> 1928.that I last saw him alive on Feb 25<sup>th</sup> 1928.and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia(duration) yrs. mos. 3 ds.CONTRIBUTORY (Secondary) Measles(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) A. C. Manning M. D.2-25, 1928 (Address) 323 E North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

West Mount Cemetery2/26 1928

20 UNDERTAKER

ADDRESS

William Cook502 E North Ave

This is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30983

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 East Virginia ST.)

## 2-FULL NAME

(a) RESIDENCE No. 14 East Virginia ST.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

E 30983

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11, 1910

7 AGE Years 7 Months 9 Days 14 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Andrews J. Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine E. Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Andrew J. Nicholas 14 East Virginia St.

15 Filed 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 12, 1928, to Feb 25, 1928.

that I last saw him alive on Feb 24, 1928,

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C. W. Buser, M. D.

2-25, 1928 (Address) 4936 Park Heights Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Cemetery

2/27, 1928

20 UNDERTAKER

ADDRESS

William Cook

502 E North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30984

## CERTIFICATE OF DEATH.

90 E 30984

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 Kennedy St. 9-46 WARD)

2-FULL NAME *Shnelia Jane Brown*

(a) RESIDENCE No. 1913 Kennedy St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widowed*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Peter Brown*6 DATE OF BIRTH (month, day, and year) *April 26 1841*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*86 9 29*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*London England*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 25 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 14 1928* to *Feb 25 1928*that I last saw her alive on *Feb 25 1928*and that death occurred, on the date stated above, at *1159 A.M.*

The CAUSE OF DEATH\* was as follows:

*Heart Insufficiency*

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*L. M. C. Cook*, M. D.2/25, 1928 (Address) *1114 Harford Rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Baltimore Cemetery**2/28 1928*

20 UNDERTAKER

ADDRESS

*William Cook**507 E/Vorth*

See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30985

## CERTIFICATE OF DEATH

129E 30985

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 703 N. Glover St., 7-12 Ward)

## 2-FULL NAME

Peter Nelson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

703 N. Glover

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S. if of foreign birth 52 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced, HUSBAND of

WIFE of

Sadie Nelson

## 6 DATE OF BIRTH (month, day, and year)

Feb 15/33

## 7 AGE

Years

Months

Days

73

8

IF LESS than 1 day... hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Paint Merchant

(c) Name of employer

Himself

## 9 BIRTHPLACE (city or town)

(State or country)

Sweden

## 10 NAME OF FATHER

Peter Nelson

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Sweden

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Sweden

## 14

Informant (Address)

Mrs Sadie Nelson 703 N. Glover St

15 Filed 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 23/28

## 17

I HEREBY CERTIFY, That I attended deceased from 2/15/28 to 2/23/28 that I last saw him alive on 2/23/28 and that death occurred, on the date stated above, at 11:50 P.

## The CAUSE OF DEATH\* was as follows:

Cardio-Vascular - Renal - arterio-sclerosis &amp; hypertension. Ch - nephritis.

## CONTRIBUTORY (Secondary)

(duration) 4 yrs. mos. ds. Cerebral thrombosis. (duration) 6 yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? No.

What test confirmed diagnosis? Salivary test + Blood test

(Signed) John F. L. M. D.

19 (Address) 722 N. Kenwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Woodlawn

2/27 1928

## 20 UNDERTAKER

ADDRESS

Philip Herzig 2016 Orleans

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26-A Co.-200 Bks.

E 30986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Sydenham Hospital)

2-FULL NAME

Richard J. Davis

(a) RESIDENCE NO.

2205 Barclay

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. ✓ mos. 3 ds.

St. 12-50 Ward)

REGISTERED NO.

E 30986

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 Color or Race

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

✓

6 DATE OF BIRTH (month, day, and year)

Sept 21, 1921

7 AGE

Years

Months

Days

6

5

3

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore, Md

(State or country)

10 NAME OF FATHER

Harry Davis

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Baltimore, Md

12 MAIDEN NAME OF MOTHER Mildred Taylor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md

14

Informant

(Address)

Hospital records

15 Filed

19

Registrar

R.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

February 24, 1928

19

17

I HEREBY CERTIFY, That I attended deceased from

February 24, 1928, to February 24, 1928.

that I last saw him alive on February 24, 1928.

and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH\* was as follows:

Measles (Convalescent)

CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

14 da.

(duration)

yrs.

mos.

6 da.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Bachman, M. D.

(Address) Sydenham Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt. Olive & Cem

Feb. 26, 1928

UNDERTAKER

Wm. J. Tucker Sons

ADDRESS

N. Y. Pa



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E-30987  
E 30987

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

CITY OF BALTIMORE: (No. 814 N. Calvert

11-15 WARD)

2-FULL NAME Ella E. Nagle

(a) RESIDENCE NO. 814 N. Calvert

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos.

ST. WARD

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed,  
or Divorced, (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than  
1 day, hrs. or min.  
About 68 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Dress Maker(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Long Green, Balto. Co.  
(State or country) Maryland

10 NAME OF FATHER Patrick Nagle

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget McCarthy

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Ireland14 Informant Miss Rose Kearney  
(Address) 814 N. Calvert Street15 28-1928 JAMES JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25 1928

17 I HEREBY CERTIFY, That I attended deceased from  
2/7 1928 to 2/25 1928.  
that I last saw him alive on 2/25 1928  
and that death occurred, on the date stated above, at 150 P.M.  
The CAUSE OF DEATH\* was as follows:  
Cerebral HemorrhageCONTRIBUTORY (Secondary) (duration) 14 mos. 14 ds.  
Cerebral Hemorrhage  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) F. H. Kearney, M. D.

19 (Address) 28 E. Madison

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL DATE OF BURIAL

St. John's Cem. Long Green 2/28 1928

20 UNDERTAKER ADDRESS

Henry W. Mears, Son 805 N. Calvert



OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26-A Co.-200 Bks.

*Jacob C Davis*  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
6.30988 CERTIFICATE OF DEATH

118-001 E 30988

1-PLACE OF DEATH

City of BALTIMORE: (No. *105* St. *105* Ward)

2-FULL NAME

(a) RESIDENCE NO. *600 Wyanette Ave* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *1* mos. *1* ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male*

*White*

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Ellen Davis*

6 DATE OF BIRTH (month, day, and year) *Feb 18 1857*

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

*70*

*0*

*8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Builder*

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Jacob C Davis*

*Baltimore*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

*Martha Deffen*

*Baltimore*

14

Informant

(Address)

*Hugh Hendon*

27 1928

HARRISON JONES, M. D.

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-26-28*

19

17 I HEREBY CERTIFY, That I attended deceased from *3/8/28* 19 to *2/26/28* that I last saw him alive on *7/6/28* and that death occurred, on the date stated above, at *6:20* m.

The CAUSE OF DEATH\* was as follows:

*Relational Hemorrhage from left epigloic artery*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of *7/8/28*

Was there an autopsy? *No*

What test confirmed diagnosis? *Chemical*

(Signed) *John A. Jones, M. D.*

(Address) *1100 Gile Street*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

Date of Burial

*London Park Ave*

*Feb 29 1928*

20 UNDERTAKER

ADDRESS

*Joseph B Cook*

*1003 N. Luth*

30989 HEALTH DEPARTMENT—CITY OF BALTIMORE 30989.

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*CITY OF BALTIMORE: (No. *1028 W. Franklin* ST. *18-76* WARD)2-FULL NAME *Samuel Outen*(a) RESIDENCE NO. *1028 W. Franklin* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*April 4, 1889*

7 AGE

Years

*38*

Months

*10*

Days

*22*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Carpenter*

(c) Name of employer

*Mo. Pie Co.*

9 BIRTHPLACE (city or town) (State or country)

*Worcester Co. Md.*10 NAME OF FATHER *Henry Clay Outen*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Worcester Co.*12 MAIDEN NAME OF MOTHER *Ritchey*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Worcester Co.*

14

Informant (Address)

*Jos. W. Outen*

15

Filed

19

*217 Cedar St. Pocomoke*  
*HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 26 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 23*, 1928, to *Feb 26*, 1928,that I last saw him alive on *Feb 26*, 1928and that death occurred, on the date stated above, at *2:50* p. m.

The CAUSE OF DEATH\* was as follows:

*Bronchopneumonia on left*  
*Lobar pneumonia in rt.*  
*Pneumococci septicaemia.*(duration) yrs. mos. ds. *6*CONTRIBUTORY (Secondary) *Empyema rt. side*(duration) yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death?

*Thorotomy*Did an operation precede death? *Yes* Date of *Feb 26, 1928*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. F. Huse*

M. D.

19

(Address)

*University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Pocomoke*

DATE OF BURIAL

*2/26 28.*

20 UNDERTAKER

*A. C. Braumig & Son*

ADDRESS

*1136 Poplar St.*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**E 30990**

PLACE OF DEATH

City of BALTIMORE: (No. 4417 Harford Avenue St. 27-44 Ward)2-FULL NAME Mary A. Warner(a) RESIDENCE NO. 4417 Harford Avenue St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of August F. Warner6 DATE OF BIRTH (month, day, and year)  
Unknown7 AGE Years Months Days IF LESS than  
Abt. 76 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work. None(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....  
(State or country) South Carolina10 NAME OF FATHER Mr. Robinson11 BIRTHPLACE OF FATHER (city or town).....  
(State or country) South Carolina12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) Unknown14 Informant Mrs. Adeline Acomb  
(Address) 123 S. Bouldin Street15 Filed FEB 27 1928 C. HAMPTON JONES, M.  
Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 23, 1928 19217 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.)and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pulmonary Odema-Myocardial Failure  
Fractured Skull-Accidentally fell at  
church Feb 19/28

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) [Signature] M. D.

(Coroner)

2/25/28 (Address) 508 E. North Avenue\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death:.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVALLoudon Park Cemetery Feb. 27, 1928FUNERAL TAKEN BY [Signature] ADDRESS 1003 W.Baltimore StOF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is  
very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30991

## CERTIFICATE OF DEATH.

197 E 30991

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 E. Madison St. ST. 10-14 WARD)

2-FULL NAME *Harvey Smith*(a) RESIDENCE NO. *1203 St. James*  
(Usual place of abode)

Length of residence in city or town where death occurred

*Life*

mos.

ds.

ST.

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*colored*5 Single, Married, Widowed,  
or Divorced (write the word)*married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Grace Smith*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

*40*If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

*Store*9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*Solomon Phillips*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*va*

12 MAIDEN NAME OF MOTHER

*Grace Blackwell*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*va*14 Informant  
(Address)*Grace Smith  
1002 Millman St.*

15

Filed *26* 1928 *HAMPSON JONES, JR.*

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 23 1928*17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an *Inquiry*  
thereon and from the evidence obtained by said *Inquest, autopsy or inquiry.**Inquiry* find that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Bullet wound in head-Homicide*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner.)

M. D.

2/25/28, 192 (Address) *38 E. North Ave*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or  
Recent Residents.)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

*Union Cemetery Feb 27 1928*

ADDRESS



PHYSICIANS should state  
Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 30992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 30992

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5037, Caroline ST. 7-9 WARD)

2-FULL NAME Adeline M. Stewart Height

(a) RESIDENCE NO. 5037, Caroline (Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Height

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE Years 79 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Brunswick Co. (State or country) Va.

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Ellen Warrall (Address) 5037 N. Caroline St.

15 FEB 26 1928 HANESON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1928

17 I HEREBY CERTIFY That I attended deceased from Jan 20 1928 Feb 24 1928 that I last saw alive on Feb 23 1928 and that death occurred, on the date stated above, at 3 40 m. The CAUSE OF DEATH\* was as follows:

Chronic Degenerative Interosclerosis (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Biopsy

(Signed) J. H. Jones M. D. (Address) 508 Summit St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Asbury Cemetery Feb. 28 1928 ADDRESS Chris. H. Johnson 16 N. Caroline St.



210814  
E 30993

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 30993

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL* ST. *5-8* WARD)2-FULL NAME *Walter Marshall*(a) RESIDENCE No. *52 N. Eden* ST. *m* WARD *m*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male black single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *8-6-85*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*42 6 18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Janitor 070*9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*

10 NAME OF FATHER

*Peter Marshall*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Md*

12 MAIDEN NAME OF MOTHER

*Sarah Stafford*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Md*

14

Informant  
(Address)*Records*

15

B 27 1928

HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 24 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 3 1928, to Feb 24 1928.*that I last saw him alive on *Feb 24 1928.*and that death occurred, on the date stated above, at *4:05 A. m.*

The CAUSE OF DEATH\* was as follows:

*Arteriosclerosis - Arteriosclerosis  
Arterio-sclerotic Kidney Disease  
Myocardial Insufficiency - Hypertension  
found normal in 1923 ~~at that time~~ unable to tell, was  
not seen again until 2-3-28  
CONTRIBUTORY *acute pulmonary edema.*  
(duration) yrs. mos. 1 ds.*18 Where was disease contracted  
if not at place of death?*No Particular place*

Did an operation precede death?

*No* Date of

Was there an autopsy?

*Yes*

What test confirmed diagnosis?

*Phthalein-NPN-Autopsy*

(Signed)

*Raymond Wing.*

M. D.

4/27, 1928 (Address)

*Johns Hopkins Hospital  
Baltimore Md.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*Asbury Cem**Feb 27 1928**Mrs. G. Sicks**1802 Hylan*

This is very important. See instructions on back of certificates. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**E 30994**  
PLACE OF DEATH

**E 30994**  
REGISTERED NO.

City of BALTIMORE: (N. *Pears*) 2700 oak St. *12-50* Ward

2-FULL NAME *Edwin R. Adams*

(a) RESIDENCE NO. *2917 St Paul st* St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred *57* yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*  
5a If married, widowed, or divorced HUSBAND of *Grace Burkhardt* (or) WIFE of  
6 DATE OF BIRTH (month, day, and year) *Nov. 14-1870*  
7 AGE Years *57* Months *3* Days *7* IF LESS than 1 day.....hrs. or.....min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Brother*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Self*  
(c) Name of employer

9 BIRTHPLACE (city or town) *Ind*  
(State or country)

10 NAME OF FATHER *M. W. Adams*

11 BIRTHPLACE OF FATHER (city or town) *Ind*  
(State or country)

12 MAIDEN NAME OF MOTHER *Laura C. Bradley*

13 BIRTHPLACE OF MOTHER (city or town) *Ind*  
(State or country)

14 Informant *Grace B. Adams*  
(Address) *2917 St Paul st*

Filed **EB 27 1928** C. HANSON JONES, II  
Per *R. M. L.* Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/24* 192*8*

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* and that said deceased came to death *on the day stated above.*  
The CAUSE OF DEATH\* was as follows:  
*Carbon monoxide gas*  
*from automobile*  
*(accidental)*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

### CONTRIBUTORY (Secondary)

(Signed) *John H. Morrison* M. D.  
(Coroner)  
*22, 1928* (Address) *3632 Roland me*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*Gruid Ridge* *Feb 27 1928*  
20 UNDERTAKER *Wm. Mitchell* ADDRESS *1900 Eastern Ave*

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30995

## CERTIFICATE OF DEATH

101-001  
E 30995  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 234 S. Robinson St., 1 Ward)2-FULL NAME William H. Weber(a) RESIDENCE NO. 234 S. Robinson St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3rd 19267 AGE Years 2 Months 21 Days 0 IF LESS than 1 day 0 hrs. or 0 min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. Md.  
(State or country)10 NAME OF FATHER Wm. Weber11 BIRTHPLACE OF FATHER (City or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Elizabeth Valentini13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Wm. Weber (Father)  
(Address) 234 S. Robinson St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 19 2817 I HEREBY CERTIFY, That I attended deceased from 2/21/28 1928 to 2/24/28 1928that I last saw him alive on 2/24/28 1928and that death occurred, on the date stated above, at 5:00 p. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) 0 yrs. 0 mos. 0 ds.

## CONTRIBUTORY

(Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Lungs(Signed) Wm. Weber M. D.(Address) 3015 Ellwood St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Sacred Heart CemeteryFeb. 27 19 2820 UNDERTAKER Willy & Jones Inc.

ADDRESS

403 S. Wolfe St.Every item of Informa-  
RECORD. Every item of Informa-  
tion should be stated EXACTLY. PHYSICIANS should state CAUSE  
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is  
very important. See instructions on back of certificates.

27 1928

C. H. JOHNSON JONES, M. D.  
Registrar

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 30996

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2200 E Pratt ST. 1-3 WARD)

2-FULL NAME Fannie Katz

(a) RESIDENCE NO. 2200 E Pratt (Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? 32 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan

6 DATE OF BIRTH (month, day, and year) 11-11-1882

7 AGE Years 82 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Harry Norwitsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Frank Katz (Address) 622 N Washington St

15 Filed FEB 27 1928 HANCOCK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb 17 1928 to Feb 25 1928, that I last saw him alive on Feb 25 1928, and that death occurred, on the date stated above, at 1 P. M. The CAUSE OF DEATH\* was as follows: Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Cecil S. Jones M. D.

19 (Address) 1634 E. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

MOIAL Feb 27 1928

UNDERTAKER H. H. Herring

Address 1127 E Balto St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30997

## CERTIFICATE OF DEATH.

E 30997  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2829 Guilford ST., WARD 50)

## 2-FULL NAME

Ruth G. Wilkinson

## (a) RESIDENCE NO.

2829 Guilford ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wm. B. Wilkinson

6 DATE OF BIRTH (month, day, and year)

May 15 1895

7 AGE

32

Years

9

Months

10

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Wm. M. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Sophia Fleming

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mrs. Stewart 2829 Guilford ST.

15

Filed

FEB 27 1928 HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 1928, to Feb 25, 1928, that I last saw her alive on Feb 23, 1928

and that death occurred, on the date stated above, at 60 in

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 1 ds.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? in

What test confirmed diagnosis?

(Signed) S. W. Spruery, M. D.

19 (Address) 1812 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Buried at 2/28/28

20 UNDERTAKER

ADDRESS

J. J. Moran E. Balch

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 30998

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Colonial Hosp.* St. *W 54* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *Maggie M. Littleton* St. *Belmont Manchester* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 4-1874*7 AGE Years *53* Months *6* Days *20* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School Teacher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) *Pittsville, Wicomico Co Md*10 NAME OF FATHER *James C Littleton*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Wicomico Co Md*12 NAME OF MOTHER *Sallie M Richardson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Wicomico Co Md*14 Informant (Address) *James C Littleton*  
*Manchester Md*15 Filed *FEB 27 1928* REGISTRAR187-001  
E 30998  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 24 1928*

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH is as follows: *Fall, down Plaster Shaft.**Multiple Fractures*  
(duration) yrs. mos. *1 hr.*CONTRIBUTORY (secondary) *Shock.*(duration) yrs. mos. *1 hr.*(Address) *4318 Bway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial

*Western Cem* *2-27-28*20 UNDERTAKER *Robert Brooks & Son* ADDRESS *Cathlamet*

PHYSICIANS should state  
Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Eka.

E 30999

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 John.

2-FULL NAME Rose J. Akers

(a) RESIDENCE NO. 1611 John.

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds.

ST. WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Robt Akers

6 DATE OF BIRTH (month, day, and year) March 20<sup>th</sup> 1863

7 AGE Years 64 Months 11 Days 4 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer at home

9 BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER James McAlister

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Boone

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Mrs Mildred Akers (Address) 1611 John St

15 Filed 27-1928 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24<sup>th</sup> 1928

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1927, to Feb 24, 1928, that I last saw him alive on Feb 24, 1928, and that death occurred, on the date stated above, at 5:05 P. M.

The CAUSE OF DEATH\* was as follows: Myocarditis chronic

(duration) yrs. 7 mos. ds. CONTRIBUTORY (Secondary) Bronchitis acute

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? A

Did an operation precede death? no Date of A

Was there an autopsy? X

What test confirmed diagnosis? none

(Signed) J. Ken Williams M. D. (Address) 601 Carrollton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Woodlawn Cmn

DATE OF BURIAL

20 UNDERTAKER Est B Harb 1158 West St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. PHYSICIANS should state EXACTLY. Exact statement of OCCUPA-

Spec. - 1-10-21-M&T-1500 Bks.

E 31000

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3303 Keene ave. 27-43 WARD)

2-FULL NAME Theresa P. Smith

(a) RESIDENCE No. 3502 Keene ave. Hamilton WARD

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John P. Smith

6 DATE OF BIRTH (month, day, and year) June 13 1846

7 AGE 82 Years 8 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER J. Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lagerton Md.

12 MAIDEN NAME OF MOTHER Theresa Bauman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Thomas Hand (Address) 3302 Keene ave

15 Filed 27 1928 C. HAMPSON JONES, M. D. Registrar

129 E 31000

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 1928 to Feb 25 1928 that I last saw her alive on Feb 23 1928

and that death occurred, on the date stated above, at 5:25 P. m. The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos. ds. CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 20 yrs. mos. ds. 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? (Signed) Bernard E. Beach, M. D.

19 (Address) 2229 St. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St Mary Cem. - German

20 UNDERTAKER George F. Rutt 1735 W. 1st Ave.

DATE OF BURIAL Feb 28 1928

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 101-001 E 31001

E 31001

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2707 Fenwick Ave 46 Ward)

## 2-FULL NAME

Mrs. Louise M. Starkloff

(a) RESIDENCE NO. 2707 Fenwick Ave Ward 9

(Usual place of abode)

Length of residence in city or town where death occurred

1 yr 11 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 Color or Race

White

5 ~~Single~~ Married, Widowed, or Divorced (write the word)

Widowed

6a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Late Ernest A. Starkloff

6 DATE OF BIRTH (month, day, and year)

Sept. 15 1862

7 AGE

65

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

10 NAME OF FATHER

Henry Black

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Louise Black

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant (Address)

Edward J. Starkloff  
2707 Fenwick Ave

15

Filed

C. H. Jones, M. D.  
Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 23 -

1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 17 1928 to Feb. 23 1928

that I last saw her alive on Feb. 23 1928

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) .....yrs. ....mos. 7 ds.

CONTRIBUTORY

(Secondary)

Acute Bronchitis

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. J. Zimmerman

2/24/28 (Address) 9858 Harford Rd.

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Landon Park Cemetery Feb 27 1928

20 UNDERTAKER

ADDRESS

Jung - f. Puth 1735 Harford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is  
 OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.  
 VERY IMPORTANT.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31002  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

CITY OF BALTIMORE: (No.

ST. 9-17 WARD)

2-FULL NAME

Mrs Marie L. Bohar

(a) RESIDENCE NO.

2431 Monroe St N.E. Wash. D.C.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

yrs.

mos. 3

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Otto Bohar

6 DATE OF BIRTH (month, day, and year)

Aug 28, 1895

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

32

5

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Housewife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town  
(State or country)

Baltimore, Md.

10 NAME OF FATHER

James M. Erdman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Mary J. Carlos

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant

Otto Bohar

(Address)

2431 Monroe St N.E. Wash.

15

Filed

C. HAMPDEN JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 12, 1928, to Feb. 25, 1928,

that I last saw her alive on Feb. 25, 1928,

and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH\* was as follows:

Sub. Acute Endocarditis?

Pulmonary Embolism - 12 days

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Cardiac Failure

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

at home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

H. Lawrence Fabrey, M.D.

, 19

(Address)

St. Joseph's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

A.P. David Riggs Cemetery

Feb. 28 1928

20 UNDERTAKER

ADDRESS

George - J. Ruth - 1735 Hayford Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31003

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2132 Aliceanna ST. 1-3 WARD)2-FULL NAME Helen. Tangier.(a) RESIDENCE NO. 2132 Aliceanna ST. 1-3 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced (write the word)5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) May 6 19277 AGE Years 9 Months 19 Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER James Tangier11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.12 MAIDEN NAME OF MOTHER Ann Maguire13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.14 Informant James Tangier (Address) 2132 Aliceanna15 File 1928 HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 192817 I HEREBY CERTIFY, That I attended deceased from July 25 1928 to July 25 1928, that I last saw her alive on July 25 1928, and that death occurred, on the date stated above, at 1. A m.

The CAUSE OF DEATH\* was as follows:

Acute Coronary  
Intoxication(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary)

Septicemia (duration) yrs. 9 mos. — da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Velez M. D., 19 (Address) 1450 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodburn CemeteryFeb 27 1928

20 UNDERTAKER

ADDRESS

George J. Ruck 1735 Harford

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

FEB 27 1928

E 31004

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31004

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Jefferson ST., 6-9 WARD)

## 2. FULL NAME

Christina Wunderlich

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

2005 Jefferson

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Married (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofComad Wunderlich

6 DATE OF BIRTH (month, day, and year)

Mar 7 - 1862

7 AGE

Years

65

Months

3

Days

17If LESS than  
1 day. hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workat home(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore

10 NAME OF FATHER

Henry Rippel11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Catherine Rippel13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Germany

14

Informant  
(Address)Mrs Gene Baughman  
2005 Jefferson

15

Filed

FEB 27 1928 HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/27/1928

17

I HEREBY CERTIFY, That I attended deceased from

July 20, 1928, to July 27, 1928,

that I last saw him alive on

and that death occurred, on the date stated above, at 12:20 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Geo E. Bladed

M. D.

, 19

(Address) 143 W 12th St\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALMount Carmel

DATE OF BURIAL

Feb 27, 1928

20 UNDERTAKER

John W. Wicks

ADDRESS

2008 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31005

## CERTIFICATE OF DEATH.

E 31005

1-PLACE OF DEATH *Church Home - Infirmary*CITY OF BALTIMORE: (No. *Broadway & Fairmount St.* WARD *57*)2-FULL NAME *Mrs Florence Eder*REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)(a) RESIDENCE NO. *1032 North Patterson St.* WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Samuel B. Eder*6 DATE OF BIRTH (month, day, and year) *Nov. 10, 1861*7 AGE Years Months Days *60* *3* *15* (If LESS than 1 day, hrs. or min.)

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Annapolis* (State or country) *Ind.*10 NAME OF FATHER *Francis A. Hamilton*11 BIRTHPLACE OF FATHER (city or town) *New York* (State or country)12 MAIDEN NAME OF MOTHER *Susan C. Jane*13 BIRTHPLACE OF MOTHER (city or town) *Ind.* (State or country)14 Informant *Mrs. Samuel H. Eder* (Address) *1032 N. Patterson St. W.*15 *HAMPTON JOHNS, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 24* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *Feb 20*, 19 *28*, to *Feb 24*, 19 *28*, that I last saw her alive on *Feb 24*, 19 *28*, and that death occurred, on the date stated above, at *7:45 P.m.*

The CAUSE OF DEATH\* was as follows:

*Diabetes mellitus*(duration) *6* yrs. mos. ds.CONTRIBUTORY (Secondary) *Intestinal obstruction* (duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *yes*What test confirmed diagnosis? *Autopsy*(Signed) *George H. Hill*, M. D.19 (Address) *Church Home & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Oak Lawn Cem.**Feb. 28 1928*

20 UNDERTAKER

ADDRESS

*For J. Kerr**1864 Luzerne*

FEB 27 1928

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31006

## CERTIFICATE OF DEATH.

E 31006

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 N. Bentall St., 16-68 WARD)

## 2-FULL NAME

Allie Muse Reeder

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1222 N. Bentall St.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Alphonse Reeder

## 6 DATE OF BIRTH (month, day, and year)

Dec 23, 1859

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

68

2

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Va.

## 10 NAME OF FATHER

A. Alexander Muse

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Bellie Beasley

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

## 14

Informant (Address)

Alphonse A. Reeder, 1222 N. Bentall St., Baltimore, Md.

## 15

Filed

19

Per

R. L. H. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 24, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from 9/16/1927 to Feb 24, 1928 that I last saw her alive on Feb 24, 1928 and that death occurred, on the date stated above, at 9.50 P.M.

## The CAUSE OF DEATH\* was as follows:

Ulcer of Stomach, Unsuccessful Resuscitation, Chronic Nephritis.

(duration) yrs. 0 mos. ds.

## CONTRIBUTORY (Secondary)

Arthritis

(duration) 2 yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

## Was there an autopsy?

## What test confirmed diagnosis?

Clinical, 27 Feb 1928 (Address) 2000 Hallis St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Greenmount Cem.

Feb. 27, 1928

## 20 UNDERTAKER

## ADDRESS

Wm. J. Tucker Sons

North &amp; Pa

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

X

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31007

## CERTIFICATE OF DEATH.

E 31007

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Linden Ave. ST. 14-20 WARD)

## 2-FULL NAME

George E. Lane

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1416 Linden Ave. ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower.5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meta Chambers Lane6 DATE OF BIRTH (month, day, and year) Oct. 16, 18617 AGE Years 66 Months 4 Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator(b) General nature of industry, business, or establishment in which employed (or employer) Retired(c) Name of employer D. & O. R. R.

## 9 BIRTHPLACE (city or town) (State or country)

Howard Co. Md.

## 10 NAME OF FATHER

John L. Lane

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Elizabeth Barlow

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant (Address)

Miss Berrie M. Lane  
1416 Linden Ave.

## 15

Filed

FEB 27 1928

HARRISON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26, 1928

17

I HEREBY CERTIFY, That I attended deceased from

July 1927 to Feb 28, 1928that I last saw him live on Feb 25, 1928and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Obstruction

(Signed)

A. C. Smith, M. D.(Address) 4329 Guilford Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Mount View Cem. Md.Feb. 29, 1928

## 20 UNDERTAKER

## ADDRESS

Wm. H. HinesNoted

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31008

## CERTIFICATE OF DEATH.

46 E 31008

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No Church Home &amp; Infirmary WARD)

## 2-FULL NAME

Mrs. Mary V. Markley

## (a) RESIDENCE NO.

3809 Clifton Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Harry A. Markley

## 6 DATE OF BIRTH (month, day, and year)

Sept. 28 1893

## 7 AGE

44

4

29

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Belghmans Island Md.

## 10 NAME OF FATHER

Addison Harrimone

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Mary ?

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

## 14

Informant (Address)

Harry A. Markley 3809 Clifton Ave.

Filed

FEB 27 1928

C. H. JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 26 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1928, to Feb. 26, 1928, that I last saw her alive on Feb. 26, 1928, and that death occurred, on the date stated above, at 4:40 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma (metastatic from cervix uteri)

(duration) 1 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Nephrosis (ureteral obstruction) duration) yrs. ? mos. 14 ds.

## 18 Where was disease contracted, if not at place of death?

at home

Did an operation precede death? over Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy

(Signed) H. J. Jones, M. D.

Feb. 26, 1928 (Address) Church Home Infirmary

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Belghmans Island Md

Feb. 29, 1928

## 20 UNDERTAKER

Wm. Tucker Sons

## ADDRESS

North Sta



E 31009

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31009

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2138 Hollis*)ST. *70369* WARD2-FULL NAME *Lorenz Beck*(a) RESIDENCE NO. *2138 Hollis*

(Usual place of abode)

ST. *70* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Mary C Beck*

6 DATE OF BIRTH (month, day, and year)

*Jan. 1, 1858*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*69 6 23*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Crew Master*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Cleburne*

10 NAME OF FATHER

*Christian Beck*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Cleburne*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*

14

Informant (Address)

*MRS. MARY C. BECK*

FEB 27 1928

*HARRISON JONES, M. D.*

Registers

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 24 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 2 1928*, to *Feb 22 1928*.that I last saw him alive on *Feb 22 1928*.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Angina Pectoris -*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Myocardial Infarction*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Charles H. Jones*, M. D.*Feb 19 28* (Address) *2000 Hollis St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Eastern Sons**Feb 27 1928*

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

E 31010

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Sq. Hosp.*CITY OF BALTIMORE: (No. *100 N. Calhoun* ST. *16-22* WARD)2-FULL NAME *Maggie Fortling*(a) RESIDENCE NO. *2008 W. Lanvale*

(Usual place of abode)

Length of residence in city or town where death occurred *2 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Dec 17th 1855*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years *75* Months *1* Days *9* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*nothing*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*10 NAME OF FATHER *John Fortling*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Maryland*12 MAIDEN NAME OF MOTHER *Sarah Little*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Maryland*

14

Informant

(Address)

*Mary Fortling*  
*2008 W. Lanvale*

FEB 27 1928

Filed

19

C. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-25* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from *2-18* 19*28* to *2-25* 19*28*.that I last saw her alive on *2-25* 19*28*.and that death occurred, on the date stated above, at *1 A* m.

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dilatation*  
*Chronic Myocarditis.*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *Yes* Date of *2-18-28*Was there an autopsy? *No*What test confirmed diagnosis? *Examination*(Signed) *Louis N. Tollin* M. D.19 (Address) *Franklin Sq. Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Rd 28 1928*

ADDRESS

*Josiah Syfer 1600 N. North*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E-31011 DEATH

CITY OF BALTIMORE: (No. *210930*)*JOHNS HOPKINS HOSPITAL* ST *5-9* WARD)2-FULL NAME *Gertrude Jenkins*(a) RESIDENCE No. *525 E. Eden ST*

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred *10* yrs

mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 *Single, Married, Widowed, or Divorced, (write the word)* *Married*5a If married, widowed, or divorced *Widowed* (or) WIFE of *John*6 DATE OF BIRTH (month, day, and year) *1909*7 AGE *19* Years Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*10 NAME OF FATHER *Thomas Dixon*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va*12 MAIDEN NAME OF MOTHER *Albrite Gann*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va*14 Informant *Bierls* (Address)

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb-24 1928*17 I HEREBY CERTIFY that I attended deceased from *Feb-7 1928* to *Feb-24 1928* that I last saw her alive on *Feb-24 1928* and that death occurred, on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Edema of cerebellum (Benign)*(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *Yes* Date of *Feb. 18, 1928*Was there an autopsy? *Yes, limited to head*What test confirmed diagnosis? *Clinical, operative, autopsy*(Signed) *Francis S. Roman* M. D.*2-25-1928* (Address) *Johns Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Norge Va.**2/27 1928*

20 UNDERTAKER

ADDRESS *1218**Byron Wright**McEldey*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

FEB 27 1928

H. M. D. Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31012

## CERTIFICATE OF DEATH

REGISTERED NO.

E 31012

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Sydenham Hospital* St. *8-17* Ward)2-FULL NAME *Francis X Henry*(a) RESIDENCE NO. *1513 N Bond St* St. *4* Ward *4*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Feb. 20, 1922*

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

*6**0**6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore*

10 NAME OF FATHER

*Albert J. Henry*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Balto.*

12 MAIDEN NAME OF MOTHER

*Mary E. Murphy*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto.*

14

Informant (Address)

*Albert J. Henry*  
*1513 N Bond St*

15 Filed

16

HAMPSON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 26, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 11, 1928, to Feb 26, 1928*that I last saw him alive on *Feb 26, 1928*and that death occurred, on the date stated above, at *7:25 p.m.*

The CAUSE OF DEATH\* was as follows:

*Laryngeal Diptheria*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

da.

*Lobar Pneumonia*

(duration)

yrs.

mos.

da.

*6*

18 Where was disease contracted

If not at place of death?

*Home*

Did an operation precede death?

*Intubated 2/11/28*

Date of

Was there an autopsy?

What test confirmed diagnosis?

*Clinical*

(Signed)

*Myron G. Sull*

M. D.

*2/27 1928*

(Address)

*Sydenham Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Cathedral**Feb 27, 1928*

20 UNDERTAKER

ADDRESS

*Beta Windefield 914 Greenmount*

tion should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS OCCUPATIONS should be stated EXACTLY. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

FEB 27 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31013

## CERTIFICATE OF DEATH.

E 31013

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2406 Ken Oak* ST. *27-54* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Margaret E. Hall*(a) RESIDENCE NO. *2406 Ken Oak* ST. *Resident* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *70* yrs. *4* mos. *12* ds. How long in U. S., if of foreign birth? *70* yrs. *4* mos. *12* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced

(or) WIFE of

*John R. Hall*6 DATE OF BIRTH (month, day, and year) *10.13.1857*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*70* *4* *12*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)10 NAME OF FATHER *John Parker*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Roxanna Ferguson*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Iowa*14 Informant *Ragn Hall*  
(Address) *2406 Ken Oak*15 Filed *27* 19*28* *HAMMON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2.25* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 10* 19*28* to *Feb. 24* 19*28*, that I last saw her alive on *Feb. 24* 19*28*.and that death occurred, on the date stated above, at *8:15 A.* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma - Intestinal*(duration) *2* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *yes* Date of *Jan 18 26*Was there an autopsy? *no*What test confirmed diagnosis? *Cephalin*(Signed) *L. H. Bellet* M. D.2.25, 1928 (Address) *West Washington*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Western Cemetery*

DATE OF BURIAL

*Feb 27 1928*

20 UNDERTAKER

*Stewart Mowello*

ADDRESS

*Baile*

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

E 31014

## HEALTH DEPARTMENT - CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Light

ST. 24-33 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

0 yrs 0 mos 4 ds.

ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 70 yrs 2 mos 9 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced

(HUSBAND of  
(or) WIFE of

Anna K Wells

6 DATE OF BIRTH (month, day, and year)

Dec 17 1857

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

70

2

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

General Merchandise

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Sudley Creek, Maryland  
Co. Md.

10 NAME OF FATHER

Benjamin F. Wells

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Sudley Md.

12 MAIDEN NAME OF MOTHER

Susan Paddy

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

14

Informant  
(Address)

Wm J Wells Jr.

15

FEB 27 1928

HARRISON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 26 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 22, 1928, to Feb 26, 1928,

that I last saw him alive on Feb 26, 1928,

and that death occurred, on the date stated above, at 6:29 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY  
(Secondary)

Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical Findings

(Signed)

C. W. Maxson

M. D.

2/26, 1928 (Address)

827 N. Ches St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

New Cathedral Cemetery

Feb 29, 1928.

UNDERTAKER

ADDRESS

B. J. JONES COMPANY

108 W. NORTH AVE

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31015

## CERTIFICATE OF DEATH.

92E 31015

1-PLACE OF DEATH

Mr Hope Retires

CITY OF BALTIMORE: (No.

ST.,

WARD)

2-FULL NAME

Ellen Sullivan

(a) RESIDENCE NO.

Mr Hope Retires

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day,.....hrs.  
or.....min.

73

2

Unknown

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town)  
(State or country)Philadelphia  
Pa

10 NAME OF FATHER

Michael Sullivan

11 BIRTHPLACE OF FATHER (city or town)

County Cork  
Ireland

(State or country)

12 MAIDEN NAME OF MOTHER

Mary Kirby

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)County Cork  
Ireland

14

Informant  
(Address)Mr Hope Retires  
Mr Hope Retires

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 24 1928

17

I HEREBY CERTIFY, that I attended deceased from

Apr 1, 1923, to Feb. 24, 1928,

that I last saw her alive on Feb. 25, 1928,

and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH\* was as follows:

Congestion of the  
(due to thrombosis)

(duration) yrs. mos. 25 ds.

CONTRIBUTORY  
(Secondary)

(duration) 16 yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical

(Signed)

Walter P. Hill

M. D.

, 19 (Address)

Mr Hope Retires

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Lancaster Penna Feb 29 1928  
Stewart & Son

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

FEB 27 1928





E 31017

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31017

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Howard A. Kelly Hospital*  
 CITY OF BALTIMORE: (No. *1418* *Entaw Place* ST. *14-70* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Helene Nussle' Philippe*

(a) RESIDENCE NO. *274 Vine Ave. Lake Forest, Illinois*  
 (Usual place of abode)

Length of residence in city or town where death occurred *8* yrs. *8* mos. *8* ds. How long in U. S., if of foreign birth? *33* yrs. *3* mos. *8* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced  
 HUSBAND of *Francois Philippe*  
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 27, 1860*

7 AGE *67* Years *3* Months *29* Days If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Teacher*

(b) General nature of industry, business, or establishment in which employed (or employer) *none*

(c) Name of employer *none*

9 BIRTHPLACE (city or town) *France*  
 (State or country)

10 NAME OF FATHER *Maurice Nussle'*

11 BIRTHPLACE OF FATHER (city or town) *France*  
 (State or country)

12 MAIDEN NAME OF MOTHER *Catherine'*

13 BIRTHPLACE OF MOTHER (city or town) *France*  
 (State or country)

14 Informant *Branice Philippe (daughter)*  
 (Address) *274 Vine Ave. Lake Forest*

15 Filed *1928* 19 *HAMPSON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 27 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Feb. 6*, 1928, to *Feb. 27*, 1928, that I last saw her alive on *Feb. 26*, 1928, and that death occurred, on the date stated above, at *4:20 A. M.*  
 The CAUSE OF DEATH\* was as follows:

*Carcinoma of the bladder -  
 Pycelonephritis*

*unknown* (duration) yrs. mos. ds.

CONTRIBUTORY *Broncho-pneumonia*  
 (Secondary) *10 days* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *unknown*

Did an operation precede death? *No* Date of *no*

Was there an autopsy? *No*

What test confirmed diagnosis? *lymphatic exam*  
 (Signed) *Margaret C. Vibes*, M. D.

, 19 (Address) *1418 Entaw Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Cremated & Buried at London Park Cemetery* DATE OF BURIAL *Feb 27, 1928*

20 UNDERTAKER *Chas. G. Black 7420 North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31018

## CERTIFICATE OF DEATH.

66 E 31018

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 529 W. Lanvale St. 17-24 Ward)2-FULL NAME Herman Brown(a) RESIDENCE NO. 529 W. Lanvale St. 17-24 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Anna Brown (or) WIFE of6 DATE OF BIRTH (month, day, and year) Jan - 19017 AGE Years 27 Months 1 Days 1 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Balto. Md10 NAME OF FATHER Peter Brown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md12 MAIDEN NAME OF MOTHER William Brown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md

## 14

Informant Edward Brown  
(Address) 529 W. Lanvale St.

## 15

Filed Feb 27 1928

H. A. JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

10 DATE OF DEATH (month, day, and year) Feb - 24 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.)and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably acute dilatation of the heart  
(duration) 2 yrs. 2 mos. 4 ds.

## CONTRIBUTORY (Secondary)

(Signed) W. H. Jones M. D.  
(Coroner)425, 19 28 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 16 PLACE OF BURIAL, CREMATION OR REMOVAL

W. Auburn

## 20 UNDERTAKER

John R. Owens

Date of Burial

Feb 28 1928

ADDRESS

578 Balph

tion should be carefully supplied. Exact statement of occupation of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

FEB 27 1928

E 31019

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31019

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 5307 Garrison Ave. ST. 27-56 WARD)2. FULL NAME John Henry Stewart(a) RESIDENCE NO. 5307 Garrison Ave. ST. 27-56 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 18 ds.Now long in U. S., if of foreign birth 2 yrs. 0 mos. 0 ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.4 COLOR OR RACE W.5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E. Stewart6 DATE OF BIRTH (month, day, and year) May 8<sup>th</sup> 1857

7 AGE

Years 70Months 9Days 18

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Express Messenger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Dry Goods Co.9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER John H. Stewart11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Malinda M. Helton13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Informant (Address) R. W. Stewart  
5307 Garrison Ave.

15

Filed 27 1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1927, to Feb 26, 1928, that I last saw him alive on Feb. 26, 1928, and that death occurred, on the date stated above, at 512 A. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach (Esophageal)(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of \_\_\_\_\_Was there an autopsy? No.What test confirmed diagnosis? X Ray.(Signed) T. Leake Ewell, M. D.1/27, 1928 (Address) 2945 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Quind Ridge CemFeb 28<sup>th</sup> 1928

20 UNDERTAKER

ADDRESS

Bertram J. E1723 N. Fayette Ave

CAUSE OF DEATH in plain terms, so that the layman can understand. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31020

## CERTIFICATE OF DEATH.

90 E 31020

## 1-PLACE OF DEATH

City of BALTIMORE: (N) 1212 Mascher St. 16-23 Ward2-FULL NAME Leiris E Bennett(a) RESIDENCE NO. 1212 Mascher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race colored 5 Single, Married, Widowed, or Divorced, (write the word) single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Mar 18917 AGE 37 Years 36 Months 11 Days 16 IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) m. d.  
(State or country)10 NAME OF FATHER Albert Bennett11 BIRTHPLACE OF FATHER (city or town) m d  
(State or country)12 MAIDEN NAME OF MOTHER Mario Whiteley13 BIRTHPLACE OF MOTHER (city or town) m d  
(State or country)14 Informant Maria Jentifer  
(Address) 1212 mascher st

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said Inquest  
and that said deceased came to death as  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Infantile Stenosis

## CONTRIBUTORY

(Secondary)  
Q. R. Austin (duration) yrs. mos. ds.  
Feb 8 1928 (duration) yrs. mos. ds.  
Feb 8 1928 (duration) yrs. mos. ds.  
14316 Berry (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.  
where was disease contracted, if not at place of death!

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Cambridge md Feb 27, 28

20 UNDERTAKER

Edmund Bryson ADDRESS 1631 Orleans

This should be carefully supplied. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificate.

FEB 27 1928 HAMPSHIRE JOINT REGISTRY



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31021

## CERTIFICATE OF DEATH.

129 E 31021

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2603 Loyola Southway* ST. *15-58* WARD)

## 2-FULL NAME

*Salvatore Carnaggio*

## (a) RESIDENCE NO.

*2603 Loyola Southway* ST. *15-58* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

*Unknown* yrs.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male white*

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Serafina Carnaggio*

## 6 DATE OF BIRTH (month, day, and year)

*Unknown*

## 7 AGE

*67*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

## Informant (Address)

*Charles Carnaggio*  
*2603 Loyola Southway*

## 15

## File

*27-1928*  
*G. HAMPTON JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb 25 19 28*

## 17

I HEREBY CERTIFY, That I attended deceased from *Feb 23*, 19*28*, to *Feb 25*, 19*28*, that I last saw him alive on *Feb 25*, 19*28*, and that death occurred, on the date stated above, at *8:35 P.m.*

## The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *Apoplexy* (duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

## Was there an autopsy?

## What test confirmed diagnosis?

(Signed) *Luigi S. Di Stefano, M.D.*  
*Feb 25, 1928* (Address) *4407 W. Euter*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*New Cathedral**Feb 28 1928*

## 20 UNDERTAKER

## ADDRESS

*Frank V. Cipituro**2514 E. B. St.*

TION is very important See instructions on back of certificates.

E 31022

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31022

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 Arlington Ave ST. 18-76 WARD)2. FULL NAME Elizabeth Powell(a) RESIDENCE NO. 516 Arlington Ave ST. 18-76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18607 AGE Years Months Days If LESS than 1 day, hrs or min. 68

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Samuel Richardson11 BIRTHPLACE OF FATHER (city or town) (State or country) MD12 MAIDEN NAME OF MOTHER Leah Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address) Samuel Powell  
523 N. Market St

15

Filed

27 1928 C. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24-192817 I HEREBY CERTIFY, That I attended deceased from 2-23-1928 to 2-24-1928, that I last saw him alive on 2-24-1928, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Terminal Bronchitis  
Pneumonia  
Chronic Arterial Heart  
Disease (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) W. C. Jackson, M. D.17 1928 (Address) 808 W. Barclay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

W. C. Tubman  
Samuel Heins

CAUSE OF DEATH IN plain terms, so that the layman can understand. See instructions on back of certificates.

E 31023 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 Argyle Ave.)

## 2-FULL NAME John Upson

(a) RESIDENCE NO. 1122 Argyle Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (Write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-25 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1928, to Feb 20, 1928,

that I last saw him alive on Feb 20, 1928,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH\* was as follows:

Paralytic Cerebral Hemiplegia

CONTRIBUTORY (Secondary) duration yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Arteriosclerotic Symptom (Signed) C. N. Fowles, M. D.

Feb 1928 (Address) 712 S. Maryland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

FEB 27 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31024

## CERTIFICATE OF DEATH.

E 31024

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1121 N. Gilman St. 16-22 Ward)2-FULL NAME Charlotte Brown(a) RESIDENCE NO. 1121 N. Gilman St. 16-22 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18947 AGE Years 34 Months Days IF LESS than 1 day...hrs. or...min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. Md. (State or country)10 NAME OF FATHER Mrs. Brown11 BIRTHPLACE OF FATHER (city or town) Calvert Co. Md. (State or country)12 MAIDEN NAME OF MOTHER Elizabeth Island13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)14 Informant Blanche Smith (Address) 660 Hammond15 Filed Feb 27 1925 Registrar Wm. H. Jones

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 192517 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)I have and from the evidence obtained by said Inquest and that said deceased came to her death on the day stated above.The CAUSE OF DEATH\* was as follows: Natural CausesCONTRIBUTORY Chorea (duration) 1 yrs. 1 mos. 1 ds. Feb 19 1925 (Address) 143 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Brooks Hotel Calverton19 PLACE OF BURIAL, CREMATION OR Date of Burial Feb 27 192520 ADDRESS Wm. H. Jones21 SIGNATURE Wm. H. Jones22 ADDRESS Wm. H. Jones

tion should be carefully supplied. OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31025

## CERTIFICATE OF DEATH

E 31025

REGISTERED NO.

1-PLACE OF DEATH

Charles Apartments

City of BALTIMORE: (No.

33 33 N. Charles

12-44 Ward

2-FULL NAME

Margaret Gilpin

(a) RESIDENCE NO.

33 33 N. Charles

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. 17 ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 8-1868

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

59

10

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Md.

10 NAME OF FATHER

John H. Gilpin

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary J. Gilpin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant (Address)

Mary J. Gilpin

Charles Apartments

15 Filed

16

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

Feb 25 1928

17

I HEREBY CERTIFY, That I attended deceased from

July 21, 1927, to Feb 25, 1928

that I last saw her alive on Feb 24, 1928

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH was as follows:

Atherosclerotic Goitre

CONTRIBUTORY

(Secondary)

(duration) yrs. 8 mos. da.

Chronic myocarditis

Auricular Fibrillation

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Elmer B. Freeman, M. D.

. 19

(Address) 412 Cathedral St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park

Feb 27 1928

20 UNDERTAKER

ADDRESS

John F. Denny

715 Light St

tion should be carefully supplied. Exact statement of occupation of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

FEB 27 1928

*Tall*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31026

E 31026

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hosp*)ST. *13-49* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Miss Alma Toll*(a) RESIDENCE NO. *Tudor Hall apt.*

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *37* yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 23, 1890*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*37**yr**6**4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balti Md.*

## 10 NAME OF FATHER

*George W Toll*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md.*

## 12 MAIDEN NAME OF MOTHER

*Leola Short*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md.*

14

Informant (Address)

*Mr. Hamburger?*

15

FEB 27 1928

FRANK JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 27 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 26, 1928* to *Feb 27, 1928*.that I last saw her alive on *Feb 27, 1928*and that death occurred, on the date stated above, at *2:45 PM*.

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Degeneration**0 hours* (duration) yrs. mos. ds.

## CONTRIBUTORY

*Secondary* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Frank R. Morris* M. D., 19 (Address) *Union Memorial Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

*Wood Ridge*

## DATE OF BURIAL

*Feb 29 1928*

## 20 UNDERTAKER

*John F. Denny*

## ADDRESS

*715 Lexington*

James T. Durgon  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31027

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* WARD)2-FULL NAME *James T. Durgon*(Residence in Baltimore: No. *N.E. cor. Division & Lafayette Ave.* yrs. mos. ds.)REGISTERED *E 31027*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *Feb 25*, 1918  
(Month) (Day) (Year)

7-AGE, *4* yrs. *4* mos. *4* ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Unknown*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's Infant Asylum*(Address) *Division & Lafayette Ave.*

15-

FEB 27 1928 *AMINON JONES, M.D.*  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 25*, 1918  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *2/24/28* 191, to *2/25/28* 191, that I saw him alive on *2/24/28* 191, and that death occurred, on the date stated above, at *3* m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia Bronchitis*  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) .....  
(Duration) .... yrs. .... mos. .... ds.

(Signed) *W. J. Jones* M. D.  
*7/25/28* (Address) *Medical Dept. Bldg.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. *3* ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Cemetery*DATE OF BURIAL, *Feb 27, 1928*20-UNDERTAKER *Martin P. Jones & Sons*ADDRESS *1827 N. York Ave*

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31028

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. George ST. 21-29 WARD)2-FULL NAME William Daves

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1107 S. Packer ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

malewhitesingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24-1884

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4321

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

BaltimoreMaryland10 NAME OF FATHER Frank Daves

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland12 MAIDEN NAME OF MOTHER Minnie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Records

15

File

27 1928 C. HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1928

17

I HEREBY CERTIFY, That I attended deceased from

Dec 25, 1928, to Dec 25, 1928,that I last saw him alive on Dec 25, 1928,and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH\* was as follows:

myocarditis, chronic acute  
arteriosclerosis  
hypertension(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? general & special(Signed) C. Hamilton Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Western Cemetery

DATE OF BURIAL

Dec 27 1928

20 UNDERTAKER

George L. Schwalb 201 Ind. Ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31029

## CERTIFICATE OF DEATH.

E 31029

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital*)ST. *1-2* WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Margaret Ulsch*

## (a) RESIDENCE NO.

*211 S. East St*

ST. .... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Dec. 21-1911*

## 7 AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.*16**2**4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Seamstress*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore  
md.*

## 10 NAME OF FATHER

*Thos. L. Ulsch*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Baltimore, Md.*

## 12 MAIDEN NAME OF MOTHER

*Mary Metzger*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore, Md.*

## 14

Informant  
(Address)*Mary Ulsch  
211 S. East Ave.*

## 15

Filed

FEB 27 1928

Per

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 25* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from

*2/20/28*, 19... to *2/25/28*, 19...that I last saw her alive on *2/25/28*, 19...and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH\* was as follows:

*Ruptured Appendix*(duration) yrs. mos. *8 to 12* ds.CONTRIBUTORY  
(Secondary)*General Peritonitis*(duration) yrs. mos. *4* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *yes* Date of *2/20/28*Was there an autopsy? *no*

What test confirmed diagnosis?

*Operation*

(Signed)

*J. L. Winkler*

M. D.

, 19 (Address) *Mary Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Oaklawn Cemetery*

DATE OF BURIAL

*Feb. 28* 19*28*

ADDRESS

*1737 E. Egan St.*

20 UNDERTAKER

*George W. Zirkler*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31030

## CERTIFICATE OF DEATH.

170 E 31030

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1205 E. Madison St. 10-14 Ward)

2-FULL NAME Thomas Downey

(a) RESIDENCE NO. 1205 E. Madison St. St. Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)  
Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) married

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Viola Downey

6 DATE OF BIRTH (month, day, and year) Nov 2/1899

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
28 3 21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Durham, N.C.  
(State or country)

10 NAME OF FATHER Thos. Downey

11 BIRTHPLACE OF FATHER (city or town) N.C.  
(State or country)

12 MAIDEN NAME OF MOTHER Emma Amos

13 BIRTHPLACE OF MOTHER (city or town) N.C.  
(State or country)14 Informant Wife  
(Address)

15 Filled by HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Pistol shot w wound in brain

Suicide (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) J. J. H. Jones, M. D.  
(Coroner)

2/27/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

Don should be filled in plain terms, so that it may be properly understood. See instructions on back of certificate.

PARENTS

EB 27 1928

Addressing Am  
Robert William 1515 McElderry

E 31031

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31031

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 E. Preston St.

ST. 9-18 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Donegan

(a) RESIDENCE No. 732 E. Preston St.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If ~~widowed~~, widowed, ~~divorced~~

(a) WIFE of

Owen F. Donegan

6 DATE OF BIRTH (month, day, and year) Sept. 8th, 1867

7 AGE

Years

Months

Days

60

5

18

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Timothy Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Sarah Halpin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Owen A. Donegan  
732 E. Preston St.

15

27 1928

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26th, 1928.

17

I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1928, to Feb. 25, 1928,

that I last saw him alive on Feb. 26, 1928,

and that death occurred, on the date stated above, at 6:50 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 5 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Charles O. Draper

M. D.

Feb. 17, 1928 (Address)

5 E. Road 81

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cemetery

DATE OF BURIAL

Feb. 29, 1928

20 UNDERTAKER

ADDRESS

Chas. H. Evans &amp; Son 118 W. Mt. Royal Ave.

E 31032

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31032

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 N. Lexington St. WARD 4-25)2-FULL NAME John Shelley(a) RESIDENCE NO. 605 N. Lexington St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Shelley6 DATE OF BIRTH (month, day, and year) Jan 26 517 AGE Years 77 Months 0 Days 29 If LESS than 1 day, ... hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Adam Offerman11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

## 14

Informant (Address) John Shelley

C. HAMPSON JONES, M. D.

Per RCH Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 - 192817 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1928, to Feb 25, 1928, that I last saw her alive on Feb 25, 1928 and that death occurred, on the date stated above, at 3:30 P. m. The CAUSE OF DEATH\* was as follows:Chronic MyocarditisCONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. ds. 1 (duration) yrs. mos. ds. 1

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Urinal.(Signed) John G. Jones, M. D., 19 (Address) 156 N. Milton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Frederick ParkFeb 29 1928

20 UNDERTAKER

ADDRESS

W. M. Roulson223 N. North

TION is very important See instructions on back of certificate

27 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31033

E 31033

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1609 Olean St., 69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Samuel Sullman

## (a) RESIDENCE NO.

1609 Olean St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 Color or Race

C

## 5 Single, Married, Widowed, or Divorced, (write the word)

MARRIED

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

1883

## 7 AGE

Years

Months

Days

45

IF LESS than  
1 day hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

MARRIED

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

MARRIED

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

MARRIED

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)

1609 Olean St.

## 15

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

Feb 26

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 23, 1927, to Feb 26, 1928.

that I last saw him alive on Feb 26, 1928.

and that death occurred, on the date stated above, at 8:00 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 2 yrs. mos. da.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

27, 1928 (Address) 508 S. ...

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

HOPKINS HOSPITAL FEB 27 1928

## 20 UNDERTAKER

ADDRESS

Commissioner Health.

E 31034

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31034

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 7-24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Scales(a) RESIDENCE NO. 1130 Pennsylvania Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

38

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23/1928

17

I HEREBY CERTIFY That I attended deceased from Apr. 19, 1927, to Feb. 23, 1928, that I last saw him live on Feb. 23, 1928and that death occurred, on the date stated above, at 2:00 A. M.

The CAUSE OF DEATH\* was as follows:

Multiple sclerosis(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Scales M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

UNDERTAKER

ADDRESS

27 1928

19

HAMPSON JONES, M. D. Registrar

JOHNS HOPKINS HOSPITAL

FEB 27 1928

31035

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31035

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

*Appt. Dr. Home*

CITY OF BALTIMORE: (No.

*1404 W. Lexington*

WARD)

2-FULL NAME

*Mrs. Louise G. Schofield*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

*1404 W. Lexington ST.*

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

*79* yrs.

mos.

*11* ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Feb. 14, 1849*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*79**11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*0*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

10 NAME OF FATHER

*James Ritcherson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Scotland*

12 MAIDEN NAME OF MOTHER

*Ruth M. Vey*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*York Co. Maryland*

14

Informant (Address)

*Mrs. Martha E. Baker  
1404 W. Lexington St.*

15 1928

19

File

Registries

*C. HAMPSON JONES, M. D.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 25, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Sept. 1927* to *Feb. 25, 1928*that I last saw her alive on *Feb. 25, 1928*and that death occurred, on the date stated above, at *12 P. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Esophagus*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *E. B. Garrett* M. D.*27, 1928* (Address) *508 1115 St. Paul St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mount Olivet*

DATE OF BURIAL

*Feb. 28, 1928*

20 UNDERTAKER

*George J. Smith*

ADDRESS

*153 L Hollins*

TION is very important. See instructions on reverse.

## HEALTH DEPARTMENT--CITY OF BALTIMORE E-31036

31036

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Inn Remond Hop

CITY OF BALTIMORE: (No. 27-48

ST. WARD)

2-FULL NAME

William Lincoln Owens

(a) RESIDENCE NO.

5603 York Rd

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

36

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 14, 1892

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

36

6

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Accountant

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

himself

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md

10 NAME OF FATHER

Thomas H. Owens

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Hester Hofffield

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore Md

14

Informant  
(Address)Mrs. H. Frank  
412 Lyman St

27 1928

C. HAMPSON JONES, M. D.  
Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 26 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 26, 1928, to Feb 26, 1928,

that I last saw him alive on

Feb 26, 1928

and that death occurred, on the date stated above, at

9 P m.

The CAUSE OF DEATH\* was as follows:

myocardial infarction  
- Pericarditis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Pericarditis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Yes

Date of Feb 26

Was there an autopsy?

No

What test confirmed diagnosis?

Spinal

(Signed)

Robert F. C. Williams, M. D.

2/28 1928 (Address)

Union Remond

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Woodlawn Cemetery

DATE OF BURIAL

Feb 29 1928

20 UNDERTAKER

ADDRESS

Johannah Canoles 1004 Risquith St



E 31037

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 31037

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18. N. Spurham ST., 6-9 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 18 N. Spurham St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced, HUSBAND of or WIFE of

William Proctor

6 DATE OF BIRTH (month, day, and year)

August 11, 1904

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

23

8

19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

General House

(b) General nature of industry, business, or establishment in which employed (or employer)

Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

William Proctor

11 BIRTHPLACE OF FATHER (city or town)

St. Marys, County

(State or country)

12 MAIDEN NAME OF MOTHER

Alice Proctor

13 BIRTHPLACE OF MOTHER (city or town)

Eastern Shore, Md.

(State or country)

14

Informant (Address)

Mother

15

Filed

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26, 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1928, to Feb. 26, 1928, that I last saw him alive on Feb. 26, 1928, and that death occurred, on the date stated above, at 9:15 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest Feingold, M. D.

(Address) 200 E. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Catholic Church

DATE OF BURIAL

Feb. 28, 1928

20 UNDERTAKER

Wendell J. Dippel 300 E. Pratt St.

E 31038

HEALTH DEPARTMENT—CITY OF BALTIMORE E 31038

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2087 Miller Ave* ST. *4-28* WARD)2-FULL NAME *Carl Edward Young Jr*(a) RESIDENCE. No. *2087 Miller Ave* ST. *4-28* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. *10* mos. *0* ds.How long in U. S., if of foreign birth? yrs. *10* mos. *0* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *Oct. 5 - 1927*

7 AGE

Years *—*Months *4*Days *20*If LESS than 1 day, hrs. *—* or min. *—*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *—*(b) General nature of industry, business, or establishment in which employed (or employer) *—*(c) Name of employer *—*9 BIRTHPLACE (city or town) *Balto.* (State or country) *MD.*10 NAME OF FATHER *Carl Edward Young*11 BIRTHPLACE OF FATHER (city or town) *Cumtugan* (State or country) *MD.*12 MAIDEN NAME OF MOTHER *Mrs. J. Young*13 BIRTHPLACE OF MOTHER (city or town) *Balto.* (State or country) *MD.*

14

Informant (Address) *2087 Miller Ave*

15

Filed *1928*

19

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 25 1928*17 I HEREBY CERTIFY, That I attended deceased from *Feb 25 1928* to *Feb 25 1928*that I last saw him alive on *Feb 25 1928*and that death occurred, on the date stated above, at *2:20 P.M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

CONTRIBUTORY (Secondary)

(duration) yrs. *2* mos. *1* ds.18 Where was disease contracted if not at place of death? *No*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Physician's finding*(Signed) *J. H. Jones*1928 (Address) *1729 N. Lombard St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL *Feb 28 1929*

20 UNDERTAKER

ADDRESS *George L. Schwab 4401 Buck Ave*

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31039

## CERTIFICATE OF DEATH

E 31039

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1403.71 Patterson Pk. Ave.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 1403 1 Patterson Pk. Ave.

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Alice Cullen

6 DATE OF BIRTH (month, day, and year)

Nov. 5/1853

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.

74

3

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Buffalo

(State or country)

N.Y.

10 NAME OF FATHER

Robert Cullen

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

London

12 MAIDEN NAME OF MOTHER

Mary Barrett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

London

14

Informant

(Address)

Mrs. Annie M. Martin  
1403.71 Patterson Pk. Ave.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

Feb 25 - 1928

17

I HEREBY CERTIFY, That I attended deceased from

Dec 19 - 1927 to Feb 25, 1928

that I last saw him alive on Feb 24, 1928

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis

CONTRIBUTORY  
(Secondary)

(duration) yrs. 2 mos. 6 ds.

(duration) yrs. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed)

George Albert Barden, M. D.

2/25, 1928 (Address) 1517 E North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

St. Marys Church (Lampden) 2/28 1928  
J. Walter Davis 3307 Paine St.

OF DEATH in plain terms, so that it may be understood by all. See instructions on back of certificates.

27 1928

RKH

Registrar





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31042

## CERTIFICATE OF DEATH.

E 31042

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1036 Somerset St 10-14 Ward)

2-FULL NAME Julia Schaffer

(a) RESIDENCE NO. 1036 Somerset St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

female white widow

5a If married, widowed, or divorced

HUSBAND of Andrew Schaffer  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
83

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

10 NAME OF FATHER William Grimm

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14 Informant Gabriel Schaffer

(Address) 1036 Somerset St

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 Feb 26/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY Senile Arteriosclerosis (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

2/27/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place In the  
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificate.

27 1928

G. HAMPSON JONES, M. D. Registrar

1301 E. Eager

31042

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 E Preston ST. 8512 WARD)

2-FULL NAME Howard Joseph Berger

(a) RESIDENCE No. 2317 E Preston ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26 1 28

7 AGE Years Months Days If LESS than 1 day, hrs or min. 1/2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

10 NAME OF FATHER Doney Shas Berger

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER La Balyn

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Charles D. Berger (Address) 2317 E Preston St

27-1928 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1928, to Feb 26, 1928,

that I last saw him alive on Feb 26, 1928,

and that death occurred, on the date stated above, at 11 P M.

The CAUSE OF DEATH\* was as follows:

Asphyxia Monelorum

CONTRIBUTORY (Secondary) Intense Typhus (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Chas B. Leman, M. D. 27, 1928 (Address) 714 N. Patterson St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Louden Park Bur

20 UNDERTAKER

Glodhillingsons

DATE OF BURIAL

Feb 28 1928

ADDRESS

126 Monument

E 31043

(Marie Dice)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hosp 65*)

WARD)

2-FULL NAME

*Enemie Dice*

(a) RESIDENCE No. *2300 Chelsea Terrace*

(Usual place of abode)

WARD

Length of residence in city or town where death occurred *unknown* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*F.*

*White*

*Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Harry Dice*

6 DATE OF BIRTH (month, day, and year)

*1889*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*37*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Va*

10 NAME OF FATHER

*John C. Dice*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Va*

12 MAIDEN NAME OF MOTHER

*Betty ?*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Va*

14

Informant (Address)

*Harry Dice*

Filed *27* 1928

, 19

*HAMPSON JONES, M.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*2/27 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*11/31 1927* to *2/27 1928*

that I last saw him alive on *2/27 1928*

and that death occurred, on the date stated above, at *1:15 P* in.

The CAUSE OF DEATH\* was as follows:

*Lung Abscess (Santap)*

(duration) yrs. *6* mos. *15* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*Unknown*

Did an operation precede death?

*No*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Chest X-ray*

(Signed)

*J. P. Smith M. D.*

, 19

(Address)

*Balti City Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

*Sanzier Va.*

*Feb. 28 1928*

20 UNDERTAKER

ADDRESS

*Wm. C. Black 927 Broadway*

31044

# HEALTH DEPARTMENT—CITY OF BALTIMORE

31044

## CERTIFICATE OF DEATH.

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Linden Ave.

2. FULL NAME Hannah Bamberger

(a) RESIDENCE No. 2408 Linden Ave.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 13-59 WARD

ST. WARD

(If non-resident give city or town and State) yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ansel Bamberger

6 DATE OF BIRTH (month, day, and year) Aug. 4th. 1847

7 AGE Years 80 Months 6 Days 22 If LESS than 1 day. hrs or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER David Eilau

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Lena Weil

13 BIRTHPLACE OF MOTHER (city or town) Germany. (State or country)

Informant Mr. Irvine Bamberger

(Address) 2408 Linden Ave.

27-1928

C. CAMPSON JONES, M. D.

Register

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26th. 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1928, to Feb 26, 1928, that I last saw him alive on Feb 26, 1928, and that death occurred, on the date stated above, at 6 A. m. The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage Arterio-sclerosis (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) J. Frederick Lutz, M. D.

(Address) Temple Garden Apts.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Har Sinai Cemetery

20 UNDERTAKER

David Lonsheim

DATE OF BURIAL

2/28/ 1928

ADDRESS

11830 W. Mt. Royal Ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31045

## CERTIFICATE OF DEATH.

129 E 31045

## 1-PLACE OF DEATH .

City of BALTIMORE: (No. Mercy Hospital. 11-7 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Salmon.(a) RESIDENCE NO. 629 N. Calvert St. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 4 mos. 4 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) October 21, 1865.7 AGE Years 62 Months 4 Days 4 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Philip A. Salmon.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.12 MOTHER NAME OF MOTHER Katherine Neilson

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.14 Informant Anna Irageser. (sister)(Address) 2439 N. Calvert St.15 Filed C. HAMPTON JONES, M.D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25, 1928. 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, au-inquiry find that said deceased came to her death (topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis.  
Uraemia.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds. (Signed) Otto M. Reinhardt M. D. (Coroner)2/27 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. ....mos. ....ds. In the State .....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 629 N. Calvert St. Feb. 25, 1928.

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Burial 2/28 1928  
20 UNDERTAKER W. M. Cook ADDRESS 507 E. North Ave.

very important. See instructions on back of certificate.

27-1928

31046

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31046

### 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1134 Greenmount* ST., *10th* WARD)

### 2-FULL NAME

*Florence Green*

(a) RESIDENCE NO. *1134 Greenmount* ST., *10th* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. *0* mos. *0* ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*

4 COLOR OR RACE *W*

5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Engene Green*

6 DATE OF BIRTH (month, day, and year) *Aug. 14-1867*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*60*

*6*

*14*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

10 NAME OF FATHER

*Frederic Stockdale*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Marion Russell*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

14

Informant

(Address)

*Ethel Phillips, 119 Alandale St.*

15

Filed

*C. HAMPTON JONES, M. D. Registrar*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 25 1928*

17

HEREBY CERTIFY, That I attended deceased from *Feb. 18 1928* to *Feb 25 1928*

that I last saw her alive on *Feb 25 1928*

and that death occurred, on the date stated above, at *4:15 pm*

The CAUSE OF DEATH\* was as follows:

*Influenza Gas Bladder*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *7* ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. B. Jones*, M. D.

(Address) *14370 Bway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REINTERMENT

DATE OF BURIAL

*All Saints, Reisterstown*

*2/28 1928*

20 UNDERTAKER

ADDRESS

*J. H. Cook*

*502 E North Ave*

E 31047

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31047

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Square Hospital*  
 CITY OF BALTIMORE: (No. *Culham & Fayette* ST. *27-41* WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs Anna Holzhauser*

(a) RESIDENCE NO. *15 Homestead Ave*  
 (Usual place of abode)

WARD \_\_\_\_\_

Length of residence in city or town where death occurred *life* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
 How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
 (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced  
 HUSBAND of *Frederick Holzhauser*  
 (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Sept 29, 1874*

7 AGE Years *53* Months *7* Days *28* If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife - 31*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*  
 (State or country)

10 NAME OF FATHER *August Denhardt*

11 BIRTHPLACE OF FATHER (city or town) *Germany*  
 (State or country)

12 MAIDEN NAME OF MOTHER *Lizzie Beck*

13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
 (State or country)

14 Informant *Daughter (Anna Holzhauser)*  
 (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 26 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 16*, 1928, to *Feb. 26*, 1928, that I last saw her alive on *Feb. 26*, 1928, and that death occurred, on the date stated above, at *10:25 P. m.*

The CAUSE OF DEATH\* was as follows:

*Diabetes mellitus & hypertension complicated by chronic pneumonia.*

(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

CONTRIBUTORY *Brachio-pneumonia*  
 (Secondary)

(duration) yrs. \_\_\_\_\_ mos. *21* ds. \_\_\_\_\_

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *no*

What test confirmed diagnosis? *K-way*  
 (Signed) *Elizabeth Sherman*, M. D.

19 (Address) *Franklin Square Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
 MOVAL

DATE OF BURIAL

*History Room*  
 20 UNDERTAKER *J. M. Cook*

*2/29 1928*  
 ADDRESS *502 E. North Ave*

1928

1928

1928

19

*C. HAMPSON JONES, M. D.*  
*R. R. R.* Registrar

E 31048

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31048

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12-50 ST. WARD)

## 2-FULL NAME

Mr. Charles F. Hansen

## (a) RESIDENCE NO.

2339 Bankly St.

ST. 12-WARD City

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary

## 6 DATE OF BIRTH (month, day, and year)

10-11-1862

## 7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

65

4

16

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Fleets Student-Work

## (b) General nature of industry, business, or establishment in which employed (or employer)

009

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ind -

## 10 NAME OF FATHER

Robert Hansen

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind -

## 12 MAIDEN NAME OF MOTHER

Helen Seymour

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind -

## 14

Informant (Address)

Records -

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 25 1928, to Feb 27 1928,

that I last saw him live on Feb 27 1928, and that death occurred, on the date stated above, at 1 430 m.

The CAUSE OF DEATH\* was as follows:

acute lobar pneumonia

(duration) yrs. mos. 5 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Lyman Weiths M. D.

2-27, 1928 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

London Park

2/29 28

J. M. Cook

507 E North Ave



## HEALTH DEPARTMENT-CITY OF BALTIMORE

31049

90E 31049

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

da.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 Filed

19

Registered

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

OF DEATH in plain text. See instructions on back of certificates. very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31050

90 E 31050

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1436 Henry* St. *24-33* Ward)2-FULL NAME *Catherine Clark*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *1436 Henry*St. *24-33* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *about 60* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Thomas Clark*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days

*65*

IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *Swen Bluffy*11 BIRTHPLACE OF FATHER (City or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Anna Bond*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *Catherine Freiburger**1436 Henry St.**C. HAMPTON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 25 1928*17 I HEREBY CERTIFY, That I attended deceased from *Feb 1*, 1928 to *Feb 25*, 1928that I last saw him alive on *Feb 25*, 1928and that death occurred, on the date stated above, at *11 A. M.*

The CAUSE OF DEATH\* was as follows:

*Mitral Regurgitation*CONTRIBUTORY (Secondary) *Phlebotomy*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *W. H. Campbell, M. D.*1644 *Hammond St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

*Margaret Flynn**1422 Wright St.*

OF DEATH in plain terms. See instructions on back of certificates. very important.

27 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31051

## CERTIFICATE OF DEATH.

57 E 31051

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital 4-25 Ward)2-FULL NAME John Cosgrove, Jr.(a) RESIDENCE NO. Hotel Kernan St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) June 1, 19217 AGE Years 6 Months 8 Days 24 IF LESS than 1 day.....hrs. \_\_\_\_\_ or.....min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... none  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country) Balto., Md.10 NAME OF FATHER John Cosgrove11 BIRTHPLACE OF FATHER (city or town).....  
(State or country) Conn.12 MAIDEN NAME OF MOTHER Helen Kreis13 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) Balto Md.14 Informant Hospital Records  
(Address) \_\_\_\_\_15 Filed 27 1928 C. HAMPTON JONES, M. D.Per APB Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobular Pneumonia-lower rt lung  
Diabetes Mellitus(Autopsy At Hospital)  
(duration).....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary).....

(Signed) [Signature] (Coroner)  
(Address) 508 E. North Ave2/25/28 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Ave Date of Burial Feb 28, 2820 UNDERTAKER Margaret J. Fyler ADDRESS Herricks

HEALTH DEPARTMENT—CITY OF BALTIMORE **E 31052****E 31052**

## CERTIFICATE OF DEATH.

REGISTERED NO. **100-001**

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital 73-31* WARD)2-FULL NAME *Thomas O'Connor*(a) RESIDENCE NO. *1321 Hanover* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Pauline Steinitz*6 DATE OF BIRTH (month, day, and year) *Sept 30, 1891*

7 AGE

*36*

Years

Months

Days

If LESS than 1 day... hrs. or min.

*4**26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Moore & McCornick*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*John O'Connor*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Margaret Murray*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore*

14

Informant (Address)

*Mrs. Pauline O'Connor 1321 Hanover St.*

15

Filed

*27 1928*

19

*G. HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/26/28*

17

I HEREBY CERTIFY, That I attended deceased from

*2/6/28*, 19... to *2/26/28*, 19...that I last saw him alive on *2/26/28*, 19...and that death occurred, on the date stated above, at *5:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*brach. pneumonia*(duration) yrs. mos. *26* ds.

CONTRIBUTORY (Secondary)

*cardiac dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Dr. Lawrence Zahner, M. D.*19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Cathedral Ave**Feb. 28, 1928*

UNDERTAKER

ADDRESS

*Margaret H. Flynn**1422 Highland St.*





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31054

## CERTIFICATE OF DEATH.

E 31054

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3909 Walnut Ave. ST. 11-001 WARD)2-FULL NAME Clara A. Stevens(a) RESIDENCE NO. 3909 Walnut Ave. ST. 11-001 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

James B. Stevens6 DATE OF BIRTH (month, day, and year) Dec. 20<sup>th</sup> 18637 AGE Years 64 Months 2 Days 7 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cambridge Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Florence Goller (Address) Calvin Ave. & Belair Road15 Feb 28 1928 C. H. JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 18, 1928, to Feb 27, 1928, that I last saw her alive on Feb 26, 1928, and that death occurred, on the date stated above, at 530 m.

The CAUSE OF DEATH\* was as follows:

La Grippe(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

at place of deathDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

Physical(Signed) Henry A. Jones, M.D.19-27-1928 (Address) 534 Harford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park CemeteryFeb 29 1928

20 UNDERTAKER

ADDRESS

Frederick L. Loeblin Sons Fullerton

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31055

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 11-24 Ward)2-FULL NAME Herbert M. Johnson. (C)(a) RESIDENCE NO. 339 Dolphin St. St. 11-24 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male.

Colored

Married.

5a If married, ~~XXXXXXXXXXXX~~  
HUSBAND of  
~~XXXXXXXXXX~~Lottie Johnson. (C)

6 DATE OF BIRTH (month, day, and year)

Do not know.

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.44

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workUndertaker.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Maryland.

10 NAME OF FATHER

James Johnson. (C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland.

12 MAIDEN NAME OF MOTHER

Caroline ----- (C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland.

14

Informant Lottie Johnson. (C) wife.  
(Address) 339 Dolphin St.

15 Filed

FEB 28 1926 HAMPTON JONES, M.

Registrar

E 31055

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25, 192617 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry And that said deceased came to his death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cobar Pneumonia.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signe Otto M. Reinhard M. D.  
(Coroner)2/27, 1923 (Address) 1017 E. Charles St.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place of death .....yrs. ....mos. ....ds. In the  
State .....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

339 Dolphin St. Feb. 25, 1926

Former or usual residence

19 PLACE OF BURIAL, CREMATION, OR  
REMOVAL Date of Burial

20 UNDERTAKER

Mountain View  
David E. CarterADDRESS 916

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31056

## CERTIFICATE OF DEATH.

E 31056

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Colonial Hospital St. 4 Ward 5)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zachrah Tiffitt(a) RESIDENCE NO. 502 Bloom St. St. 4 Ward 5

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX : 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male Col Single  
6a If married, widowed, or divorced HUSBAND of (or) WIFE of6 DATE OF BIRTH (month, day, and year) 18787 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
49

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....Janitor(b) General nature of industry, business, or establishment in which employed (or employer).....070

(c) Name of employer

9 BIRTHPLACE (city or town).....Md

(State or country)

10 NAME OF FATHER Charles Tiffitt11 BIRTHPLACE OF FATHER (city or town).....Md

(State or country)

12 MOTHER'S NAME OF MOTHER Catherine Reed13 BIRTHPLACE OF MOTHER (city or town).....Md

(State or country)

14

Informant Mamie Tiffitt  
(Address) 502 Bloom St15 Filed 1928Registrar R. W. Jones

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, autopsy or inquiry.

(thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc.  
Fracture of Skull  
Shock

CONTRIBUTORY (Secondary)

27/28 (Signed) G. C. D. Davis M. D.  
(Address) 143 B Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

New Cathedral Bury Feb 27 28  
Samuel Carter 916  
De me

Very Important. See instructions on back of certificate.



E 31057

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74 E 31057

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Milliman ST., 7-13 WARD)

2. FULL NAME John A. Jackson

(a) RESIDENCE NO. 1605 Milliman

(Usual place of abode)

Length of residence in city or town where death occurred

40

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

Married.

5a If married, widowed, or divorced

HUSBAND of

or WIFE of

Sarah Jackson

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

approx 70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Junk dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Anndel Co Md.

10 NAME OF FATHER

Edward Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Anndel Co

12 MAIDEN NAME OF MOTHER

Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Anndel Co

14

Informant (Address)

Blanche Mitchell daughter 807 N. Caroline St.

15

Filed, 19

HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 13, 1928, to Feb 26, 1928,

that I last saw him alive on Feb 25, 1928,

and that death occurred, on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage &amp; Paralysis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed)

2/27/28

(Address)

1424

C Monument

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cemetery

2/28 1928

20 UNDERTAKER

Theodore C. White

ADDRESS

110 N. High

E 31058

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31058

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4723 Locust Ave St. 27-48 Ward)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry Bricle

(a) Residence No. 4723 Locust Ave St. .... Ward. ....

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 7 ds. How long in U. S. if of foreign birth? yrs. .... mos. .... ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

White

5-Single, Married, Widowed, or Divorced, (Write the word.)  
Married5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of

Myrtle S. Bricle

6-DATE OF BIRTH (month, day and year) July 19 - 1878

7-AGE,

49 yrs. 7 mos. 7 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore Md (State or Country),

10-NAME OF FATHER

Henry Bricle

11-BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or Country),

12-MAIDEN NAME OF MOTHER

Emilia Kern

13-BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or Country),

14-

(Informant) Myrtle S. Bricle  
(Address) 4723 Locust Ave

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 26 1928

17- I HEREBY CERTIFY, That I attended deceased from April 15 1927 to Feb 26 1928

that I last saw him alive on Feb 26 1928

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(Duration) yrs. 10 mos. 11 ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. .... mos. .... ds.

18-Where was disease contracted  
If not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Sordy M.D.

2-27, 1928 (Address) 4218 Harford Road

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Parkwood Cem Feb 29 1928

20-UNDERTAKER ADDRESS 1039

J. Schloman &amp; Son

FEB 28 1928

HAMPSON JONES, M.D.  
Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31059

## CERTIFICATE OF DEATH.

101 E 31059

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701. N. Carey

ST. 16-23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 701. N. Carey

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 3 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

28 1928

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1928, to Feb 27, 1928, that I last saw him alive on Feb 27, 1928, and that death occurred, on the date stated above, at 7:35 p. m.

The CAUSE OF DEATH\* was as follows:

Labar Memoria

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. E. Bell, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 31060

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31060

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 511 N. Guilford)2-FULL NAME Narah Pollock(a) RESIDENCE NO. 511 N. Guilford

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.19-27  
St. Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

St. Ward

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

female color married  
If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Nm Pollock

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

46

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Laborer 070

9 BIRTHPLACE (city or town)

(State or country)

Virginia

10 NAME OF FATHER

Charles Barber

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

N.C.

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

N.C.

14

Informant  
(Address)Nm Pollock  
511 N. Guilford St.

15 Filed

1928

C. H. HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 25, 1928, to Feb 25, 1928

that I last saw her alive on Feb 25, 1928

and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 12 hrs.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hatcher, M. D.

1928 (Address) 1225 Pa St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt Auburn

2/28 28

20 UNDERTAKER

ADDRESS

John H. Hatcher

1027 Lehigh Hill Ave

very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31061

## CERTIFICATE OF DEATH

129  
REGISTERED E 31061

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2237 E Ruston 5-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 2237 E Ruston

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

2 White Widowed  
5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Thomas Kelly

6 DATE OF BIRTH (month, day, and year) Sep 8. 1863

7 AGE Years 65 Months 5 Days 18 IF LESS than 1 day hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)Harold S. Jones  
2237 E Ruston

16 Filed

B 28 1928

19

C. H. HARRISON-JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 28

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 24, 19 28, to Feb. 26, 19 28.

that I last saw him alive on Feb. 26, 19 28.

and that death occurred, on the date stated above, at 11:45 Am.

The CAUSE OF DEATH\* was as follows:

Uraemic Coma  
(duration) yrs. mos. ds.CONTRIBUTORY Chronic Diffuse Nephritis  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical Signs

(Signed) J. E. Heimer, M. D.

Feb. 27, 19 28 (Address) 1301 N. Park Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Baltimore Conn Feb 27 1928

20 UNDERTAKER

ADDRESS

Mendell Wappel 37 Wm

E 31062

## HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 31062

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Home wood Apartments 3120* St. *7-50* Ward)2-FULL NAME *Thomas P. Loney*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *Home wood Apartments* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *7* yrs. *7* mos. *5* ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Grace Richardson* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 21, 1856*7 AGE Years *71* Months *7* Days *5* IF LESS than 1 day hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *retired*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Grain Broker*  
(c) Name of employer9 BIRTHPLACE (city or town) *Balto*  
(State or country)10 NAME OF FATHER *Thomas D. Loney*11 BIRTHPLACE OF FATHER (City or town) *Md.*  
(State or country)12 MAIDEN NAME OF MOTHER *Julia Poudgates*13 BIRTHPLACE OF MOTHER (city or town) *Md.*  
(State or country)14 Informant *Mrs. Grace P. Loney*  
(Address) *Home wood Apartments*15 Filed *FEB 28 1928*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 26-28*17 I HEREBY CERTIFY, That I attended deceased from *Jan 12, 1927* to *Feb 26, 1928*  
that I last saw him alive on *Feb 25, 1928*  
and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*myocardial disease + arteriosclerosis*(duration) *1* yrs. *1* mos. *1* ds.CONTRIBUTORY *Pulmonary edema*  
(Secondary)(duration) yrs. mos. *2* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *usual*(Signed) *Stanley M. Loney*, M. D.19 (Address) *1609 Linden Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Green Mount Feb 28 1928*

20 UNDERTAKER

ADDRESS

*Ornithall Thomas*

very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31063

## CERTIFICATE OF DEATH.

31 E 31063

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 17-25 WARD)

2-FULL NAME George N. Carroll

(a) RESIDENCE No. 515 N. Pine st.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos.

ST. 17-25 WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Carroll

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE Years 26 Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Washington (State or country) D.C.

10 NAME OF FATHER Geo. S. Carroll

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Florence Powell

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Hospital Records (Address)

15 Filed 1/24, 19 1928 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 19 28, to Feb. 25, 19 28, that I last saw him alive on Feb. 25, 19 28.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis  
Pleurisy with effusion  
unknown duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Subacute meningitis  
Broncho-pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted Unknown if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. M. Maddux, M. D.

2-25-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-INTERMENT

St. Luke's Church 7/28/28

UNDERTAKER Sumner H. Hensley, Inc. ADDRESS

31064

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31064

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 574 St Marys St. 17-24)

REGISTERED NO.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Smith

(a) RESIDENCE. No. 574 St Marys St. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Cal 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE 66 Years Months Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore MD

10 NAME OF FATHER John Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hester Widen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14

Informant (Address)

Carrie Smith 574 St Marys St.

15

Filed

19

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24 1928

17

I HEREBY CERTIFY, That I attended deceased from for the past year to 2-24 1928 that I last saw her alive on 2-24 1928.

and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? her home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical (Signed) J. H. Jones, M. D.

Address) 117 W. Saratoga St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REINTERMENT DATE OF BURIAL

20 UNDERTAKER

ADDRESS

TION is very important. See instruction on reverse side.

FEB 28 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31065

## CERTIFICATE OF DEATH.

199 E 31065

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 425 Ward)2-FULL NAME Robert Hendricks alias George Henry(a) RESIDENCE NO. 614 W. Fairmount Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX \_\_\_\_\_ 4 Color or Race \_\_\_\_\_ 5 Single, Married, Widowed, or Divorced, (write the word) \_\_\_\_\_

Male Negro Married

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Lillie Hendricks

6 DATE OF BIRTH (month, day, and year) \_\_\_\_\_

7 AGE \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min. 41

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Steel Plant

(c) Name of employer

Bethlehem Steel Co.

9 BIRTHPLACE (city or town)

(State or country)

Va.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

P. A. Lomax

(Address)

1400 1/2 F. St. Wash. D.C.

15 Filed

FEB 28 1926HAM

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 192517 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

autopsy and that said deceased came to his death (Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Homicide  
Fracture of the Skull

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Laceration of Brain

(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

2/26 1925 (Address) 2732 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Washington D.C. 7/28 '25

20 UNDERTAKER

ADDRESS

James Hensley McCall

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31066

## CERTIFICATE OF DEATH.

91-002  
E 31066

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2134 Druid Hill Ave Ward 14-59)

## 2-FULL NAME

Augusta Fough

## (a) RESIDENCE NO.

21340 Druid Hill Ave

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)Female Colored Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofGeorge

## 6 DATE OF BIRTH (month, day, and year)

1806

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.72

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workNone(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Md.

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant  
(Address)Nabel Braxton  
21340 Druid Hill Ave

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19 28February 24

## 17

I HEREBY CERTIFY, That I attended deceased from

Oct 24, 1927, to Feb 24, 1928,that I last saw him alive on Feb 24, 1928,and that death occurred, on the date stated above, at 1 P.m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis(duration) 2 yrs. 4 mos. 4 ds.CONTRIBUTORY  
(Secondary)Cerebral degeneration(duration) 6 yrs. 6 mos. 6 ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of.....Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.Feb. 25, 1928 (Address) 20050 Druid Hill Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Laurel Cemetery2/28/1928

## 20 UNDERTAKER

ADDRESS

Mrs. Geo. H. Hollan 1601 Druid Hill Ave

very important. See instructions on back of card.

FEB 28 1928

HAMPSON JONES, M. D.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31067

## CERTIFICATE OF DEATH.

90 E 31067

## 1-PLACE OF DEATH

City of BALTIMORE: No. 715 S Dallas St., 34 Ward)2-FULL NAME John Samelka(a) RESIDENCE NO. 715 S Dallas St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 28 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Anna Samelka (or WIFE of)6 DATE OF BIRTH (month, day, and year) Oct 25 18847 AGE 44 Years Months Days IF LESS than 1 day.....hrs. or.....min.8 OCCUPATION OF DECEASED Labor

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel(c) Name of employer Baito Dry Dock Plant Poland

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland14 Informant Anna Samelka (Address) 715 S Dallas Street

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an. Inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocard Stenosis  
Coronary Artery  
Arteriosclerosis  
1436 PerryCONTRIBUTORY (Secondary) Arteriosclerosis  
1436 Perry  
1436 Perry

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Rosary Cemetery March 1 192820. UNDERTAKER George A Weber ADDRESS 2205 Bank St

Very Important. See instructions on back of certificate.

PARENTS

FEB 28 1928 HAMPSON JONES, Registrar





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31069

## CERTIFICATE OF DEATH.

E 31069

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2450 Fredk Ave 20-69 St. 20-69 Ward)

## 2-FULL NAME

Mrs. Dora V. Gumpman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO

2450 Fredk Ave St. 20-69 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced. (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Felix J. Gumpman

## 6 DATE OF BIRTH (month, day, and year)

June 29, 1889

## 7 AGE

Years

Months

Days 27IF LESS than  
1 day.....hrs.  
or.....min.38728

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housework

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant

(Address)

## 15

Filed

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Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 26 Feb 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

19 Feb 1928, 10 26 Feb, 19 28that I last saw him alive on 26 Feb, 19 28and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia, Lobar  
Both lower lobes.

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Physical signs(Signed) F. J. Gumpman, M. D., 19 (Address) 2560 Fredk Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Western Cemetery Feb. 29, 1928

## 20 UNDERTAKER

ADDRESS 3109Chas. W. Dill. Fredk Ave.

very important. See instructions on back of card.

B 28 1928

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31070

CERTIFICATE OF DEATH.

89

E 31070

1-PLACE OF DEATH

City of BALTIMORE: (No. 49 E Woodland St., 27-56 Ward)

2-FULL NAME George J. Lando

(a) RESIDENCE NO. 49 E Woodland St., 27-56 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? 22 yrs. — mos. — ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose

6 DATE OF BIRTH (month, day, and year) Mar 22 1874

7 AGE Years 54 Months 11 Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Russia  
(State or country)

10 NAME OF FATHER Louis T. Lando

11 BIRTHPLACE OF FATHER (city or town) Russia  
(State or country)

12 MAIDEN NAME OF MOTHER Alice Ginsberg

13 BIRTHPLACE OF MOTHER (city or town) Russia  
(State or country)

14 Informant Rose Lando  
(Address) 49 E Woodland

15 File No. 26 1926 16 Registrar C. H. Jones

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Pneumonia  
Pectoris  
(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —  
(Signed) J. H. M. D. (Coroner)

18 ADDRESS 49 E Woodland

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto Hebrew Cemetery Date of Burial Feb 28 1928

20 UNDERTAKER So. of Minson + Bur ADDRESS 1127 E Balto

PARENTS

3

# HEALTH DEPARTMENT—CITY OF BALTIMORE

31071

1-PLACE OF DEATH

*St. Agnes Hospital*

CERTIFICATE OF DEATH.

E 31071

CITY OF BALTIMORE: (No.

ST. 25-72 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Theresa Collins*

(a) RESIDENCE NO. *6 Belmont Ave. Catonsville Md.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

*25* ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female*

*White*

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*April 15, 1922*

7 AGE

*Years*

Months

Days

If LESS than 1 day, hrs or min.

*90*

*12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Md.*

10 NAME OF FATHER

*John Collins*

11 BIRTHPLACE OF FATHER (city or town)

*Maryland*

(State or country)

12 MAIDEN NAME OF MOTHER

*Ruth B. Boily*

13 BIRTHPLACE OF MOTHER (city or town)

*Maryland*

(State or country)

14

Informant (Address)

*Hospital Records*

15

*28 1928*

*HARRISON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 27 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 2nd, 1928*, to *Feb. 27, 1928*.

that I last saw him alive on *Feb 27, 1928*

and that death occurred, on the date stated above, at *10:55 p.m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*

(duration)

yrs.

mos.

*12* ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical*

(Signature) *Augustine Von Schuel* M. D.

19 (Address)

*St. Agnes Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. John's Cems.*

*Mar. 1, 28*

20 UNDERTAKER

ADDRESS

*Easton Sons Ellicott City*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 31072**  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

**E 31072**

CITY OF BALTIMORE: (No. **530 N Caroline** ST. **5-9** WARD)

2-FULL NAME **Mary E Brown**

(b) RESIDENCE NO. **530 N Caroline**

(Usual place of abode)

Length of residence in city or town where death occurred **40** yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX **F**

4 COLOR OR RACE **C**

5 Single, Married, Widowed, or Divorced, (write the word) **Widowed**

5a If married, widowed, or divorced (husband or wife of) **Etannd Brown**

6 DATE OF BIRTH (month, day, and year) **unknown**

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

**Approx 64**

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **Home**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) **Sticksburg**

10 NAME OF FATHER **Nathaniel Cook**

11 BIRTHPLACE OF FATHER (city or town) (State or country) **Ad.**

12 MAIDEN NAME OF MOTHER **Alpha**

13 BIRTHPLACE OF MOTHER (city or town) (State or country) **Ad.**

14

Informant (Address) **Mrs. Curvina Payne sister**

Filed **61 66 278**

**HARRISON JONES** Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **Feb 26 1928**

17

I HEREBY CERTIFY, That I attended deceased from **Nov**, 1927, to **Feb 26**, 1928.

that I last saw him alive on **Feb 24**, 1928.

and that death occurred, on the date stated above, at **11:30 A.M.**

The CAUSE OF DEATH\* was as follows:

**Chronic Parenchymatous Nephritis**

(duration) yrs. **4** mos. ds.

CONTRIBUTORY (secondary) **Mitral Insufficiency and Hypertension & Atherosclerosis**

18 Where was disease contracted if not at place of death?

Did an operation precede death? **No** Date of

Was there an autopsy? **No**

What test confirmed diagnosis? **Physical**

(Signed) **R. J. Gentry**, M. D.

**2/26/28** (Address) **1429 E Monument St**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL **Mt. Zion Cem.**

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

**Mrs. J. Locks**

**Feb 29, 28**  
**1302 Jefferson**



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31073

## CERTIFICATE OF DEATH.

E 31073

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)2-FULL NAME John Horvath.(a) RESIDENCE NO. 25 Third Ave. Wagners Point Sec. 5 Ward 10

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. -- mos. -- ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 35 yrs. -- mos. -- ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Widower.6a If ~~XXXXXX~~ widowed, ~~XXXXXX~~ HUSBAND of ~~XXXXXX~~ Anna Horvath.6 DATE OF BIRTH (month, day, and year) October 28, 18867 AGE Years 41 Months 8 Days 28 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Hungary.10 NAME OF FATHER Nicholas Horvath.11 BIRTHPLACE OF FATHER (city or town)..... (State or country) Hungary.12 MAIDEN NAME OF MOTHER Marie Frombach.13 BIRTHPLACE OF MOTHER (city or town)..... (State or country) Hungary.14 Informant Martin Horvath (brother) (Address) 214 E. Gouldin St.15 Filled C. HAMPTON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26, 1928.17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest. (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said autopsy and inquest find that said deceased came to his death on the day stated above.The CAUSE OF DEATH\* was as follows: Fracture of the ribs causing laceration of the liver & lungs. Internal hemorrhage struck and knocked down by an automobile Accidental death.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds. (Signed) [Signature] M. D. (Coroner)2/28, 1928 (Address) 1017 E. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Hanover St. Bridge Feb. 25, 1928.

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross & Co Date of Burial 2-29 192820 UNDERTAKER Ex B. Hall ADDRESS 1158 West St

EB 28 1928

31074

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital 76-37* ST. *76-37* WARD)2-FULL NAME *Wm H Gibson*(a) RESIDENCE NO. *Balti City Hospital* ST. *76-37* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

129 E. 31074  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male Colored Married*a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Emily Gibson*

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*58*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer - 040*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Maryland*

10 NAME OF FATHER

*unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*unknown*

12 MAIDEN NAME OF MOTHER

*unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*unknown*

14

Informant  
(Address)*Emily Gibson  
11330 Stockton St.*

15

Filed

19

*H. JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-26* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from

*1-18* 19 *28*, to *2-26* 19 *28*that I last saw him *live* on *2-26* 19 *28*and that death occurred, on the date stated above, at *4:00* m.

The CAUSE OF DEATH\* was as follows:

*Generalized Osteosclerosis  
Chronic Myocarditis, Chronic  
Subacute Nephritis*CONTRIBUTORY  
(Secondary)*Terminal Bronchopneumonia*(duration) yrs. mos. *2* ds.18 Where was disease contracted  
if not at place of death?*Home*Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Thymus Signet*  
*J. B. Jones* M. D., 19 (Address) *Balti City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Mt. Zion Cemetery**Feb 29, 28*

UNDERTAKER

ADDRESS *322**Mrs Kate R. Williams**R. Schroeder*

# HEALTH DEPARTMENT-CITY OF BALTIMORE

E 31075

## CERTIFICATE OF DEATH.

E 31075

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *4001 Edmondson Ave* ST. *70-71* WARD)

### 2-FULL NAME

(a) RESIDENCE No. *4001 Edmondson Ave* ST. *70-71* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced, (write the word)

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Filed

19

HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 27 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 11 1928* to *Feb. 26 1928*, that I last saw her alive on *Feb. 26 1928*, and that death occurred, on the date stated above, at *12:15 A* m. The CAUSE OF DEATH\* was as follows:

*Angina Pectoris*

(duration) yrs. mos. *15* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Isaac C. Dickson*, M. D.

*4428 1928* (Address) *3055 W. North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 31076

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31076

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 Gough St. 2nd

ST. 2nd WARD)

## 2. FULL NAME

Wladyslawa Sosnowski

## (a) RESIDENCE NO.

1836 Gough St.

(Usual place of abode)

Length of residence in city or town where death occurred

20 yrs. mos. ds.

ST. 2nd WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

File

B 28 1928

HARRISON JONES, M. D.  
Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 26, 1928

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1927, to Feb. 26, 1928,

that I last saw her alive on Feb. 26, 1928,

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH\* was as follows:

Acute cardiac dilatation

CONTRIBUTORY  
(Secondary)

Chronic nephritis

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

John V. Szepietowski, M. D.

, 19

(Address) 1738 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Holy Rosary  
F. W. OzazowskiFeb 29 1928  
1930  
Eastern Ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31077

## CERTIFICATE OF DEATH

31

E 31077

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 305 So. Ann

St. 2-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalene Drozd,

(a) RESIDENCE NO. 305 So. Ann

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 9 mos. 26 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 30 - 1901

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

26

9

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Gents neck ware

(b) General nature of industry, business, or establishment in which employed (or employer)

Maker,

(c) Name of employer

H. Cohn,

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, MD.

10 NAME OF FATHER

Michael Drozd,

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Poland,

12 MAIDEN NAME OF MOTHER Rosalia Bogdan,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland,

14

Informant Michael Drozd, (Father)

(Address) 305 So. Ann Street

15 Filed

C. HAMPTON JONES, M. D.

Per R. L. H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1928, to Feb. 25, 1928,

that I last saw him alive on Feb. 25, 1928,

and that death occurred, on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH\* was as follows:

Tuberculosis  
Pulmonary

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed

Feb. 27, 1928

(Address)

3508 Baux St.

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Stanislaus

Feb. 29 - 1928

UNDERTAKER

M. J. Sadowski

ADDRESS

405 S. Ann St.

FEB 28 1928



E 31079

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

71-002  
E 31079  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2038 Fountain St. 4-4 Ward)

2-FULL NAME Luis Kawalewski

(a) RESIDENCE NO. 2038 Fountain St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days 8 3 4 June 23 1927 IF LESS than 1 day...hrs. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Stanley Kawalewski

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

Mary Piorkawska

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

## PARENTS

14 Informant Mary Kawalewski (Address) 2038 Fountain St.

15 Filed G. HAMPSON JONES, M. Registrar Per [Signature]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Feb. 27 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1928, to Feb. 27, 1928, that I last saw him alive on Feb. 27, 1928, and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebro-meningitis

CONTRIBUTORY (duration) yrs. mos. 2 ds. (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? m Date of -

Was there an autopsy? m

What test confirmed diagnosis?

(Signed) John F. Ridge, M. D. 19 (Address) 2627 Eastman Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Rosary Feb. 28 1928

## 20 UNDERTAKER

ADDRESS

John M. Weber 1803 Park St.

E 31080

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31080

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 121 S Castle St. 2nd Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leokadja Kalinowska(a) RESIDENCE NO. 121 S Castle St. 2nd Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 19 Months 3 Days 11 Nov. 15 1908 IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Tailoring

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

10 NAME OF FATHER

Joseph Kalinawski

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Josephine Awakowska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

14

Informant Joseph Kalinawski  
(Address) 121 S Castle St.

15 Filed

26 1928 JOHN JONES, M. D.  
Russell Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 192817 I HEREBY CERTIFY, That I attended deceased from Feb. 20 1928, to Feb. 26 1928.that I last saw her alive on Feb. 26 1928 at 4:30 p.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:  
Lobar PneumoniaCONTRIBUTORY (duration) yrs. mos. 5 da. Acute Cardiac dilatation  
(Secondary)(duration) yrs. mos. 1 da.

18 Where was disease contracted

if not at place of death? residenceDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) David Feingold, M. D.(Address) 700 E. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Stanislaus March 1 1928

20 UNDERTAKER ADDRESS

John M. Weber 1803 Penn

very important. See instructions on back of certificate.



E 31081

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31081

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *624 S Register* St. *7-4* Ward)2-FULL NAME *Unknown*(Residence in Baltimore: No. *624 S Register* St.; yrs. .... mos. .... ds.)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Male*

4-COLOR OR RACE,

*White*5-Single,  
Married,  
Widowed,  
or Divorced.  
(Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

*40*

yrs. .... mos. .... ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),10-NAME OF  
FATHER,11-BIRTHPLACE  
OF FATHER,  
(State or Country),12-MAIDEN NAME  
OF MOTHER,13-BIRTHPLACE  
OF MOTHER,  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed

*C. HAMPTON JONES, M. D.*

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

192*8*  
(Year)

17-

I HEREBY CERTIFY that I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)*Inquest* thereon and from the evidence obtained by said *Inquest* find that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Alcoholism*CONTRIBUTORY  
(Secondary)*Exhaustion* (Duration) yrs. .... mos. .... ds. *7*  
*1928* *Feb 6* (Date) yrs. .... mos. .... ds. *1*  
*1928* (Address) *143 W 1st May* M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY

FEB 28 1928

20-UNDERTAKER,

ADDRESS

Commissioner Health,

Per W. E. WOODALL.

E 31082

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31082

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

## 2. FULL NAME

Edward Talper

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

York Beach

ST.,

WARD

Maine

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

12

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

6 If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Martha Talper

7 DATE OF BIRTH (month, day, and year)

11-2-64

8 AGE

Years

Months

Days

63

If LESS than 1 day. hrs. or min.

## 9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country)

Maine

11 NAME OF FATHER

Appleton Talper

12 BIRTHPLACE OF FATHER (city or town) (State or country)

Maine

13 MAIDEN NAME OF MOTHER

Mary Irene

14 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maine

15

Informant (Address)

Reends -

16

File

JOHNS HOPKINS HOSPITAL

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 28 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 16 1928, to Feb 28 1928, that I last saw him alive on Feb. 28 1928

and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

Coronary Thrombosis?

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes Date of 2-20-28

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

I. R. Jewell M. D.

, 19

(Address)

Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

York Beach Maine

Feb 28 1928

UNDERTAKER

ADDRESS

John O. Mitchell and Sons

1900 E. Main

place

31083

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31083

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

6303 Brook Ave. (Rogeburg) WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Beth

(a) RESIDENCE NO.

6303 Brook Ave

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

73

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles Beth

DATE OF BIRTH (month, day, and year)

3/11/1854

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

73

11

16

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Martin Gruner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Gruner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Charles Beth 6303 Brook Ave

28-1928

HAMPSON JONES, M. D.

Regist.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/27/1928

17

I HEREBY CERTIFY That I attended deceased from

Jan. 2 - 1928 to Feb. 27, 1928

that I last saw her alive on Feb. 27, 1928

and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH\* was as follows

Sclerosis of brain

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Benj. A. Hayden

M. D.

2/28/1928 (Address)

1266 N. Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery

March 2, 1928

20 UNDERTAKER

ADDRESS

John Ullrich

2605 Orleans St

E 31084

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31084

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4106 Wilson Heights*)

### 2-FULL NAME

*Augusta M. Herbst*

(a) RESIDENCE No. *4106 Wilson Heights*

(Usual place of abode)

Length of residence in city or town where death occurred *9* yrs. *9* mos. *9* ds.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *White*

5 Single, Married, Widowed, or Divorced, (write the word) *Married*

If married, widowed, or divorced HUSBAND of (or) WIFE of *August Herbst*

DATE OF BIRTH (month, day, and year) *Jan 23/1866*

AGE

*62* Years

*1* Months

*3* Days

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Germany*

10 NAME OF FATHER *Fritz Schulte*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Donna Ruth*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *August M. Herbst 4106 Wilson Heights*

15

1928

19

C. HAMPTON JONES, M.D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/27/1928*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 1*, 19 *28* to *2-27-28*. That I last saw him alive on *2-27-28*, 19 *28* and that death occurred, on the date stated above, at *5:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction*  
*Hyperlipidemia*  
*Hypertension*  
*acute Pul Edema*  
(duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) *acute Pul Edema*  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *unknown*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *pending*

(Signed) *W. H. Jones* M. D.  
*178-28-7* (Address) *100 N. 1st St.*

\*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Cemetery*

*March 1, 1928*

20 UNDERTAKER

ADDRESS

*John Whit*

*2008 Orleans St.*



E 31085

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-001 E 31085

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 11 W. Spring Ave. 27 St. 42 Ward)

2-FULL NAME John S. Keyser

(a) RESIDENCE NO. 11 W. Spring Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs.

mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced  
HUSBAND of

(or) WIFE of Rose Keyser

6 DATE OF BIRTH (month, day, and year)

Oct. 24, 1883.

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

44

4

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....

Superintendent

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer Blumenthal Mfg. Co.

9 BIRTHPLACE (city or town) Balto.

(State or country)

Md.

10 NAME OF FATHER

John S. Keyser

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Barbara Derr

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country)

Md.

14

Informant  
(Address)Mrs. Rose Keyser  
11 W. Spring Ave.

15

C. HAMPTON JONES, M. D.

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1928.

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 19, 1928, to Feb 26, 1928,  
that I last saw him alive on Feb 26, 1928,  
and that death occurred, on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH\* was as follows:

Heart dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Influenza -  
Pneumonia  
(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. V. Meyer, M. D.  
Feb 28, 1928 (Address) 1528 E. 3rd\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL

Baltimore Cem.

Feb 29 1928

20 UNDERTAKER

ADDRESS

Wm. C. Black 927 N. Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31086

## CERTIFICATE OF DEATH.

E 31086

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

1507 Ramsay

St.

Ward

## 2-FULL NAME

Julia Killean

(a) RESIDENCE NO.

1507 Ramsay

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

60

mos.

da.

How long in U. S., if of foreign birth?

yrs.

mos.

da.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Late John J. Killean

6 DATE OF BIRTH (month, day, and year)

May 1, 1852

7 AGE

Years

Months

Days

75

9

26

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Ireland

## 10 NAME OF FATHER

Michael Cusack

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Ellen McAuliff

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

## 14

Informant

(Address)

Mary E. Kaen  
1507 Ramsay St.

15 Filed

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 28, 1928

17

I HEREBY CERTIFY, That I attended deceased from

2/1/28, to

2/6/28, 1928

that I last saw him live on

2/6/28

1928

and that death occurred, on the date stated above, at

7:40

m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) ..... yrs. .... mos. .... da.

## CONTRIBUTORY

(Secondary)

(duration) ..... yrs. .... mos. .... da.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?..... Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Edward J. Verry

M. D.

Feb. 1928 (Address)

1507 Ramsay St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

REMOVAL

New Cathedral

Feb 27, 1928

## 20 UNDERTAKER

Harry H. Wylke

ADDRESS

1231 N. Lombard St.

31087

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31087

## CERTIFICATE OF DEATH.

## I. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2718 Hampden Ave 12-51 WARD)2. FULL NAME James E. Wilson(a) RESIDENCE NO. 2718 Hampden Ave ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If non-resident give city or town and State) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) marriedIf married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. WilsonDATE OF BIRTH (month, day, and year) Aug 12, 1864AGE 63 Years \_\_\_\_\_ Months 6 Days 15 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) md. (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Laura V. Wilson (Address) 2718 Hampden Ave15 8 1928 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27, 192817 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1927 to Feb. 26, 1928.that I last saw him alive on Feb 25, 1928 and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:

Chr. Em. + myo - cardiacChr. NephritisArterio - sclerosis + hypertension

(duration) ? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

CONTRIBUTORY (Secondary) Myocardial Infarct (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds. \_\_\_\_\_

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? No. Date of \_\_\_\_\_Was there an autopsy? No.What test confirmed diagnosis? Physical Evidence(Signed) Geo. B. Dybert M. D., 19 (Address) 2802 Maryland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Baltimore Cem. DATE OF BURIAL Feb 28, 192820 UNDERTAKER Phenoweth ADDRESS 3615 Chestnut Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 31088

## CERTIFICATE OF DEATH.

E 31088

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital

17-51 Ward

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorthy Ann Claggett

(a) RESIDENCE NO. 2418 Maryland Ave

St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 13/27

7 AGE

Years

Months

Days

8

14

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

none

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER Herbert A Claggett

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER Viola Byrgess

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant Father  
(Address)

15 Filed

C. HAMMOND JONES, M. D.  
Registrar

1928

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/27/28

17

I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
inquiry and that said deceased came to her death  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Diphtheritic Colitis  
Otitis Media

(Autopsy at Hopkins)

CONTRIBUTORY  
(Secondary)

(Signed)

(duration)

(Coroner)

(Address)

2/28/28

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Date of Burial

St. Marys Hampden

Feb 29<sup>th</sup> 28.

20 UNDERTAKER

ADDRESS

Phenowickson



31089

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3626 Railroad ST. 101 WARD) 101

2-FULL NAME Virgie V. Young

(a) RESIDENCE NO. 3626 Railroad ST. 101 WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred life yrs. 0 mos. 0 ds.

REGISTERED NO. 31089  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 10, 1911  
AGE 16 Years 5 Months 10 Days 10 If LESS than 1 day, hrs. 0 or min. 0

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Hand  
(b) General nature of industry, business, or establishment in which employed (or employer) 046  
(c) Name of employer

BIRTHPLACE (city or town) (State or country) md

10 NAME OF FATHER John S. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Nettie Penelope

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant John S. Young  
(Address) 3626 Railroad

15 1928 HAMPSON JONES, M. D. Registrar ARW

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26, 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb 24th, 1928, to Feb 26th, 1928, that I last saw her alive on Feb 26th, 1928 and that death occurred, on the date stated above, at 5 P. m.  
The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 8 ds.

### CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Routine  
(Signed) Chas. S. Jones M. D.  
, 19 28 (Address) 800 St 36 St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

Butler Balto Co.  
20 UNDERTAKER Chenoweth

### DATE OF BURIAL

Feb 29, 1928

### ADDRESS

3615 Chestnut

31090

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31090

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Agnes Hospital* St. *25-72* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Walter C. Thomas*(Residence in Baltimore: No. *Spring Grove State Hospital* St.; yrs. .... mos. *11/2* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,  
*Male*4-COLOR OR RACE,  
*White*5-Single, *Single*  
Married,  
Widowed,  
or Divorced,  
(Write the word.)6-DATE OF BIRTH, *Unknown*

(Month)

(Day)

(Year)

7-AGE, *About 48 years*

If LESS than 1 day,

yrs. .... mos. .... ds.

hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Attendant*(b) General nature of industry, business, or establishment in which employed (or employer), *Spring Grove State Hospital*9-BIRTHPLACE,  
(State or Country),*Virginia*10-NAME OF  
FATHER, *Unknown*11-BIRTHPLACE  
OF FATHER, *Unknown*  
(State or Country),12-MAIDEN NAME  
OF MOTHER, *Louisa*13-BIRTHPLACE  
OF MOTHER, *Virginia*  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ezra Thomas*  
*Spring Grove State Hospital*  
(Address) *Catonsville, Md.*

15-

*C. HAMPTON JONES, M. D.*Filed *8 1928*Per *APN* Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 27*

(Month)

(Day)

1928  
(Year)17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Examination* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Examination* (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Amorhage - right lung punctured*  
(Duration) *26* yrs. *15* mos. *15* ds.CONTRIBUTORY  
(Secondary)*Struck by auto*  
(Duration) *26* yrs. *15* mos. *15* ds.  
*Dr. J. B. Norton* M. D.  
*28* 1928 (Address) *Carlisle Bay*

\*State the Disease Causing Death, in cases of violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions. Transients, or Recent Residents).

At place of death. .... yrs. .... mos. .... ds. In the State. .... yrs. *6* mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence. ....

19-PLACE OF BURIAL OR REMOVAL,  
*Shawsville, Virginia*DATE OF BURIAL,  
*Feb. 28,* 19*28*

20-UNDERTAKER,

*E. Leroy Stiffler*

ADDRESS

*125 E. North Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE **E 31091****31091**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 253 W Woodland ST. 27-56 WARD) **90**2-FULL NAME Robert L. Grassmick(a) RESIDENCE No. 253 W Woodland ST., WARD (If non-resident give city or town and State)  
(Usual place of abode)Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Offie Grassmick6 DATE OF BIRTH (month, day, and year) June 8, 18797 AGE Years 48 Months 8 Days 18 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fredrick Co Md  
(State or country)10 NAME OF FATHER Bayrus Grassmick11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Anna A. Bowser13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant Mr. Grassmick  
(Address) 253 W. Woodland Ave. City15 C. HAMPSON JONES, M. D.  
R. K. H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 192817 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1928, to Feb 27, 1928, that I last saw him alive on Feb 27, 1928, and that death occurred, on the date stated above, at 9:00 P m.

The CAUSE OF DEATH\* was as follows:

Dilatation of heart  
From beating heart failureCONTRIBUTORY (Secondary) Defect of lungs  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred B. Jones, M. D.Full Address 253 W. Woodland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Meadow Brook Cemetery, Har. Co. Md. DATE OF BURIAL Mar. 1, 192820 UNDERTAKER C. M. Kattz, Winfield, Md. ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31092

## CERTIFICATE OF DEATH.

E 31092

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Harlen Ave.

ST. 16-26 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Dorethy Randolph Johnson

## (a) RESIDENCE NO.

1311 Harlem Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

Female.

## 4 COLOR OR RACE

Negro

## 5 Single, Married, Widowed,

or Divorced, (write the word)

Single

a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

July, 17th, 1920

## 7 AGE

Years

Months

Days

7

7

11

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Unemployed

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Albert Randolph.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md. ?

## 12 MAIDEN NAME OF MOTHER

Geneva Johnson

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

## 14

Informant  
(Address)

Geneva Johnson

1311 Harlen Ave.

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 28 1928

## 17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 24, 1928, to Feb. 28, 1928

that I last saw him alive on Feb. 27th, 1928

and that death occurred, on the date stated above, at

8, 30a.

The CAUSE OF DEATH\* was as follows:

Diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

At place of death.

Did an operation precede death?

No. Date of

Was there an autopsy?

Sact. Exam. Physical Exam.

(Signed)

Walter J. Jackson, M. D.

19 (Address)

1611 W. Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

MOV. Mt Auburn Bur Feb 29 1928

## 20 UNDERTAKER

## ADDRESS

Damon H. H. H.

Beane

B 29 1928



E 31093

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31093

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2409 Armat* ST. *16-68* WARD)2-FULL NAME *Rose Hainer*(a) RESIDENCE NO. *2409 Armat* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Sept 15 1849*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*78**5**15*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *Mr. M. Hainer*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Anna Lightner*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*Mrs. Jim Campbell 2409 Armat are*

15

Filed

1928

19

HAMILTON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 27 1928*

17

I HEREBY CERTIFY, That I attended deceased from *July - 17*, 1928, to *July - 27*, 1928, that I last saw her alive on *July - 25*, 1928, and that death occurred, on the date stated above, at *2450* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency, Subile, - Arteriosclerosis, Chronic Nephritis & Capitis,*(duration) yrs. *4* mos. ds.

CONTRIBUTORY (Secondary)

*Decompensation & Failure* (duration) yrs. — mos. *10* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Wesley Cole*, M. D.

(Address)

*2202 Harrison*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*London Park Feb 29 1928*  
*Mrs. Nelson Son 2503 Edmond are*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31094

## CERTIFICATE OF DEATH.

E 31094

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3217 Schaffner Ave*)ST. *Hampden*WARD *4*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Henry Viessman*

## (a) RESIDENCE NO.

*3217 Schaffner Ave*

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*life* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*

6 If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Ollie M. Viessman*

DATE OF BIRTH (month, day, and year)

*July 29-1871*

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*56**7**29*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

10 NAME OF FATHER

*Geo. Viessman*

11 BIRTHPLACE OF FATHER (city or town)

*Germany*

12 MAIDEN NAME OF MOTHER

*Margaret Martin*

13 BIRTHPLACE OF MOTHER (city or town)

*Germany*

14

Informant

*Ollie M. Viessman*

(Address)

*3217 Schaffner Ave*

15

Filed

*23 1928**HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 27 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*April**1927*, to *Feb 27**1928*.

that I last saw him alive on

*Feb 26**1928*.and that death occurred, on the date stated above, at *4:45* a. m.

The CAUSE OF DEATH\* was as follows:

*Gastric Cancer: Cardiac - End*

(duration)

*10* yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*General & Local*

(duration)

*1* yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

*Yes* Date of *Yes*

Was there an autopsy?

*No*

What test confirmed diagnosis?

(Signed)

*Dr. J. H. H. H.*

M. D.

, 19

(Address)

*125 E. Eager St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Parkwood Cemetery*

DATE OF BURIAL

*Feb 29 1928*

20 UNDERTAKER

*George W. Zirkler*

ADDRESS

*1737 E. Eager St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31095

## CERTIFICATE OF DEATH.

100-001  
E 31095

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 S. Robinson

ST. 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Felter

(a) RESIDENCE NO. 1103 S. Robinson  
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos.

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? rs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

(a) If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

John H. Felter

DATE OF BIRTH (month, day, and year) May 13-1854

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

73

9

14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER Saml Hufnagle

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Not known14 Informant Bertha H. Brown  
(Address) 1103 S. Robinson St

15

Filed

B 23 1928

H. J. JONES, Jr.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 11th, 1928, to Feb 27th, 1928, that I last saw her alive on Feb 27th, 1928, and that death occurred, on the date stated above, at 9:35 P. m.  
The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None  
(Signed) S. E. Ellwood, M. D.  
2/28, 1928 (Address) 1011 S. E. Ellwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oaklawn Cemetery

DATE OF BURIAL

Mch 2 1928

20 UNDERTAKER

George W. Zirkler

ADDRESS

1737 E. Eager St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31096

## CERTIFICATE OF DEATH.

E 31096

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *319 So Caroline* ST. *3-4* WARD)2. FULL NAME *Katherine Rose*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *319 So Caroline* ST. *3-4* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *4* mos. *18* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *F.* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced, HUSBAND of (or) WIFE of *John*DATE OF BIRTH (month, day, and year) *Oct-8-1863*AGE *64* Years *4* Months *18* Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Stitcher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *John*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *John*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*14 Informant *Mr. Charles J. Jones* (Address) *202 E. N. Ave.*15 Filed *EB-29 1928* REGISTRAR *W. H. Jones*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 26 1928*17 I HEREBY CERTIFY, That I attended deceased from *Feb 10*, 1928, to *Feb 26*, 1928, that I last saw him alive on *Feb 26*, 1928, and that death occurred, on the date stated above, at *11 P. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach*(duration) yrs. *2* mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *E. L. Pearson*, M. D. *2.28.1928* (Address) *514 Drury Lane*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*St. Pauls - Nov 1 1925*  
*Mr. Cortis 302 E. N. Ave.*



# Lochenauer

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31097

## CERTIFICATE OF DEATH.

46 E 31097

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *First Baltimore Gen. Hosp* ST. *15-68* WARD)2. FULL NAME *Mrs. Bertha Lockner*(a) RESIDENCE NO. *1632 Bradish Ave* ST. *15* WARD *68*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *W*4 COLOR OR RACE *W*5 Single, Married, Widowed,  
or Divorced, (write the word) *Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Thomas Lockner*DATE OF BIRTH (month, day, and year) *Apr 16, 1886*

AGE

Years *41*Months *10*Days *12*If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work *At home*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) *Baltimore Md*10 NAME OF FATHER *John Reese*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *Anna Byrne*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Baltimore Md*

14

Informant  
(Address) *Thomas Lockner*  
*1632 Bradish Ave*

15

Filed *1928*HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-28* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from  
*February 21, 1928*, to *February 28, 1928*,  
that I last saw her alive on *February 28, 1928*,  
and that death occurred, on the date stated above, at *5:20 P. m.*  
The CAUSE OF DEATH\* was as follows:*Post-operative shock.*

(duration) yrs. mos. ds.

CONTRIBUTORY *Carcinoma of right ovary*  
(Secondary)*with cystic degeneration* (duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *Yes* Date of *Feb. 28, 1928*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *S C Feldman* M. D.*2-28, 1928* (Address) *Washington Gen. Hosp.*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Not listed*

DATE OF BURIAL

*3/2* 19 *28*

20 UNDERTAKER

ADDRESS

*502 E. North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31098

## CERTIFICATE OF DEATH.

E 31098

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Colonial Hospital 5-21* St., *5-21* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *1717 W Pulaski* St., \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 Color or Race *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *July 13, 1902*7 AGE Years *5* Months *7* Days *14* IF LESS than 1 day.....hrs. \_\_\_\_\_ or.....min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

## 9 BIRTHPLACE (city or town)

(State or country) *Baltimore Md*10 NAME OF FATHER *George W. Stapp*

PARENTS

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) *Md*12 MAIDEN NAME OF MOTHER *Margery Russell*15 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) *Md*

14

Informant *George W. Stapp* (Address) *1717 W Pulaski St*

B 29 1928

Hampden Jones, M. D. Registrar

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 27 1928*

17 I HEREBY CERTIFY that I am in charge of the remains described above, held an \_\_\_\_\_ (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said \_\_\_\_\_

and that said deceased came to death \_\_\_\_\_

on the day stated above.

The CAUSE OF DEATH was as follows: *Auto Acc**Fracture of Skull*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CONTRIBUTORY (Secondary) *Alcohol*

\_\_\_\_\_

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# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**E 31099**  
1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2822 St Paul)

2. FULL NAME Fannie Metzler

(a) RESIDENCE NO. 2822 St Paul  
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 29 1854

AGE Years 74 Months Days If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Charles Metzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Margaret Oxtor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs M. B. Crum  
(Address) Marysville Tenn Gray Court Apt

15 Filed 8-23-1928 HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 27 1928

17 I HEREBY CERTIFY, That I attended deceased from 6 Feb 1928 to 2-27 1928. that I last saw her alive on 2-27 1928, and that death occurred, on the date stated above, at 11 m. The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY (Secondary) Central artery (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. H. Jones, M. D.

19 (Address) 117 W. Lexington St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAN

1st White Cemetery

20 UNDERTAKER William Cook

DATE OF BURIAL

2/29 1928

ADDRESS

502 E North

An

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31100

## CERTIFICATE OF DEATH.

90 E 31100

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3317 N. Rogers Ave ST. 17-55 WARD)

2-FULL NAME Charles J. Lloyd

(a) RESIDENCE NO. 3317 N. Rogers Ave ST. 17-55 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? (If non-resident give city or town and State) yrs. mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widow, or divorced HUSBAND or WIFE Margaret C Lloyd

DATE OF BIRTH (month, day, and year) Nov 16, 1871

AGE Years 56 Months 3 Days 11 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police officer Retired

(b) General nature of industry, business, or establishment in which employed (or employee)

(c) Name of employer City of Balt

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER William J Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helena Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Margaret C Lloyd 3317 N Rogers Ave

FILED B 29 1928 HANCOCK JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1928

17 I HEREBY CERTIFY, That I attended deceased from 1928 to 2/27 19 28 that I last saw him alive on 2/27 19 28 and that death occurred, on the date stated above, at 9:50 P m. The CAUSE OF DEATH\* was as follows:

Myocardial Infarction  
(duration) yrs. mos. ds. 15

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Jones M. D.

(Address) 644 N. Main St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL Greenmount

20 UNDERTAKER W. H. Cook

DATE OF BURIAL 2/27 1928

ADDRESS 502 E. North Ave



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31101

## CERTIFICATE OF DEATH.

E 31101

1-PLACE OF DEATH *University Hospital*  
 CITY OF BALTIMORE: (No. *Lombard & Greene St.* ST. *75-32* WARD)  
 2-FULL NAME *Vernon Burns*  
 (a) RESIDENCE NO. *637 1st St. Westport* ST. *Baltimore* WARD  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *51* yrs. *5* mos. *21* ds. How long in U. S., if of foreign birth? (If non-resident give city or town and State) yrs. mos. ds.

REGISTERED NO.  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*  
 If married, widowed, or divorced HUSBAND of (or) WIFE of *Elizabeth Burns*  
 DATE OF BIRTH (month, day, and year) *11-5-1876*  
 AGE Years *51* Months *3* Days *21* If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Motorman*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *Electric Railways*  
 (c) Name of employer *W. B. & A. Electric Co.*  
 9 BIRTHPLACE (city or town) (State or country) *Md.*

10 NAME OF FATHER *John Burns*  
 11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*  
 12 MAIDEN NAME OF MOTHER *Elizabeth* ?  
 13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14 Informant *Hospital Records*  
 (Address)

15 Filed *29 1928* *G. HANCOCK JONES, M. D.* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-26* 19*28*

17 I HEREBY CERTIFY, That I attended deceased from *1-28*, 19*28*, to *2-26-28*, 19*28*, that I last saw him alive on *2-26*, 19*28*, and that death occurred, on the date stated above, at *9:05 P.M.*

The CAUSE OF DEATH\* was as follows:  
*Carcinomatous of Pancreas, Liver and spleen*

(duration) *unknown* ds.  
 CONTRIBUTORY (Secondary) *Secondary pneumonia from pneumonia*  
 18 Where was disease contracted if not at place of death? *unknown* yrs. *4* mos. ds.

Did an operation precede death? *yes* Date of *2/23/28*  
 Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical findings*  
 (Signed) *Henry V. Davis* M. D.  
 Address *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Western Cemetery*  
 20 UNDERTAKER *J. Fero M. Cully*

DATE OF BURIAL

*3/1* 19*28*  
 ADDRESS *130 E. Fort*

E 31102

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Edgecomb Park 27-56

St.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Florence Polansky

(Residence in Baltimore: No.

Edgecomb Park

St.; 1 yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

single

6-DATE OF BIRTH,

Feb 28, 1927

(Month)

(Day)

(Year)

7-AGE,

1 yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,  
(State or Country),

Balto Md

10-NAME OF FATHER,

Isaac Polansky

11-BIRTHPLACE OF FATHER  
(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Dora Harris

13-BIRTHPLACE OF MOTHER  
(State or Country),

Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Isaac Polansky

(Address)

Edgecomb Park

15-

Filed

1928

C. H. JONES, M. D.

Regist.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb. 28, 1928

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1928, to Feb. 28, 1928, that I saw her alive on Feb. 28, 1928, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Isaac Polansky M. D.  
Feb. 24, 1928 (Address) 352 E. Howard St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Albany Rosedale

DATE OF BURIAL.

Feb. 29, 1928

20-UNDERTAKER

Sol. H. H. H.

ADDRESS

1127 E. Balto St.

George W Reed

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31103

## CERTIFICATE OF DEATH.

E 31103

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 n Gilman st ST. 19-27 WARD)

## 2-FULL NAME

George W Reed

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

206 n Gilman st ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed6 DATE OF BIRTH (month, day, and year) February 15, 18577 AGE 61 Years 0 Months 11 Days LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eastonshire Va (State or country)10 NAME OF FATHER Smith Reed11 BIRTHPLACE OF FATHER (city or town) Eastonshire Va (State or country)12 MAIDEN NAME OF MOTHER R King Gold13 BIRTHPLACE OF MOTHER (city or town) Eastonshire Va (State or country)

## PARENTS

14 Informant Marie Needman (Address) 919 n Mount Street

EB 29 1928

HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 19 28

17

I HEREBY CERTIFY, That I attended deceased from Feb 10, 19 28, to Feb 26, 19 28.that I last saw him alive on Feb 26, 19 28.and that death occurred, on the date stated above, at 12 05 4 m.

The CAUSE OF DEATH\* was as follows:

Bacterial pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Culture(Signed) William P. French, M. D., 19 28 (Address) 1717 E. Lexington Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mount Auburn2-29-28

UNDERTAKER

ADDRESS

Joseph A. Lively409 N. Mount

104

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. *1516 St. 15-21*)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurredSt. *15-21* WardSt. *15-21* Ward(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 Color or Race

*colored*

5 Single, Married, Widowed, or Divorced, (write the word)

*married*

6a If married, widowed, or divorced

(or) *of**Bessie Jones*

6 DATE OF BIRTH (month, day, and year)

*unknown*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.*54*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Sanitor*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Tail + merris*

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Balto md.*

10 NAME OF FATHER

*John Jones*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*md*

12 MAIDEN NAME OF MOTHER

*Margaret Owens*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*md*

PARENTS

14

Informant  
(Address)*John Jones**1033 N. Carey St*

15 Filed

*C. HAMPTON JONES, M. D.*

Per

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*10-26 1928*

17

I HEREBY CERTIFY that I am in charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

Hereon and from the evidence obtained by said

topography or inquiry.)

on the day stated above.

The CAUSE OF DEATH was as follows:

*Obstruction of Bowels*

CONTRIBUTORY

(Secondary)

*Chauvin**27/10**1431013 May*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs.,.....mos.,.....ds.

In the

State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*mt Zion cemetery**3/1 1928*

20 UNDERTAKER

*Thomas E. Nelson*

ADDRESS

*1303 Pressman St*



E 31105

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31105

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

Filed

29 1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
2-2-1928, to 2-27-1928that I last saw her alive on 2-26-1928  
and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH\* was as follows:

Terminal Bronchio Pneumonia  
Cerebral Thrombosis, right side

(duration) yrs. mos. ds.

CONTRIBUTOR

(Secondary)

Psychosis of Cerebral  
arterio-sclerosis & diabetes

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

27 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Thomas E. Nelson

3/2 1928  
1303  
Prattman St

31106

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32 E 31106

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *13-59* WARD)2. FULL NAME *Mrs. Lillian Miller*(a) RESIDENCE No. *2851 Woodbrook Ave* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. — mos. *10* ds.How long in U. S., if of foreign birth? *4* yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Arthur F. Miller*DATE OF BIRTH (month, day, and year) *February 18 1898*

AGE

Years *35*Months *—*Days *10*If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Baltimore, Md.*  
(State or country)10 NAME OF FATHER *George H. Pinner*11 BIRTHPLACE OF FATHER (city or town) *Baltimore, Md.*  
(State or country)12 MAIDEN NAME OF MOTHER *Margaret Seeling*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore, Md.*  
(State or country)

14

Informant *M. Arthur F. Miller*  
(Address) *2851 Woodbrook Ave*

15

Filed *Feb 29 1928*Registrar *R. L. [Signature]*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/28* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *9/9*, 19*27*, to *2/28*, 19*28*.that I last saw *h&n* alive on *2/28*, 19*28*.and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH\* was as follows:

*Infected Left Kidney -  
Tuberculous*(duration) yrs. *8* mos. — ds.CONTRIBUTORY *Meningitis - probably*

(Secondary)

*Tuberculous* (duration) yrs. — mos. *18* ds.

18 Where was disease contracted

if not at place of death? \_\_\_\_\_

Did an operation precede death? *No* Date of *7/27/27*Was there an autopsy? *No*What test confirmed diagnosis *Laboratory & Clinical*(Signed) *Ervin B. Wallace* M. D., 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Woodlaw Cemetery*DATE OF BURIAL *March 1 1928*20 UNDERTAKER *Henry H. [Signature]*ADDRESS *100, E. [Signature]*

E 31107

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31 E 31107

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 539 N Washington St., 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 539 N. Washington St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. 4 ds. How long in U. S. if of foreign birth? 7 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

February 24 1898

## 7 AGE

Years

Months

Days

IF LESS than 1 day — hrs. or — min..

30

—

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

## 10 NAME OF FATHER

Patrick J. Sammon

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Marie E. Sammon

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

## 14

Informant (Address)

Mr. Marie E. Sammon 416 E. 22<sup>nd</sup> St.

## 15

Filed

FEB 23 1900 JAMES J. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19 28

## 17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1927, to Feb 25, 1928

that I last saw him alive on Feb 27, 1928

and that death occurred, on the date stated above, at 7:05 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

## CONTRIBUTORY (Secondary)

(duration) 1 yrs. — mos. — ds.

(duration) — yrs. — mos. — ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Jones, M. D.

Feb. 19 28 (Address) 413 E. Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

New Cathedral Cemetery

Mar 3<sup>rd</sup> 1928

## 20 UNDERTAKER

ADDRESS

Henry H. H. H. H.

1301 E. E. E.

E 31108

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

74-001  
E 31108  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2644 Hartford Ave St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna L. Fitzgerald

(a) RESIDENCE NO. 2644 Hartford Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? Life mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female white widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Richard Fitzgerald

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day hrs. or min..  
66 1 25 April 21st 1861

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

10 NAME OF FATHER

J. W. Grant

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Polkhouse

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant  
(Address)Dr. Harry A. Goetze  
2644 Hartford Ave

15 Filed

C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1928

17

I HEREBY CERTIFY, That I attended deceased from

Nov 2, 1927, to Feb 27, 1928

that I last saw her alive on Jan 125, 1928

and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) a few seconds yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Arterio-Sclerosis

(duration) (a few years) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Morris B. Green, M. D.

2/28, 1928 (Address) Hamilton Baltimore Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt Carmel

3/1 1928

20 UNDERTAKER

ADDRESS

L. Heermann

37 S. Bway



# Imab.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31109

## CERTIFICATE OF DEATH.

E 31109

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST. B-4 WARD)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Imab.(a) RESIDENCE NO. 208 S. Broadway

(Usual place of abode)

WARD \_\_\_\_\_

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 26 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male4 COLOR OR RACE white5 Single, Married, Widowed, or Divorced, (write the word) WidowedIf married, widowed, or divorced  
HUSBAND of  
or WIFE of Mary Imab.DATE OF BIRTH (month, day, and year) Oct 29/875

AGE

Years 52Months 4Days 28If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work operator sewer(b) General nature of industry, business, or establishment in which employed (or employer) 049

(c) Name of employer

BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) Germany10 NAME OF FATHER Michael Imab.

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_

(State or country) Ireland12 MAIDEN NAME OF MOTHER Kathie13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) Ireland

14

Informant  
(Address) Records

15

Filed ED 29 1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27/1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1928 to Feb. 27, 1928 that I last saw him live on Feb. 27, 1928 and that death occurred, on the date stated above, at 4:40 A.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach  
& carcinomatosis(duration) ? yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? noDid an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? General & Spec.(Signed) C. J. Jones, M.D.

, 19 (Address) \_\_\_\_\_

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Holy Cross

DATE OF BURIAL

March 1, 1928

UNDERTAKER

ADDRESS

Wendell D. Jones 378 N

E 31110

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31110

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *760 N Hamburg St.* ST. *29* WARD)2-FULL NAME *Charles A. Beale Jr.*(a) RESIDENCE No. *760 N Hamburg St.* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed,

or Divorced, (write the word)

*Single*

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct 13/27*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*4 15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

29 1928

G. H. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-38-1928*

17

I HEREBY CERTIFY, That I attended deceased from *2/27* to *3/28*, 19*28*.that I last saw him alive on *2/28*, 19*28* at *9:45 A* m.

The CAUSE OF DEATH\* was as follows:

*Bronchus Pneumonia*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Richard D. M. D.*

19

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Bowdoin, Pk.**3-1-1928*

20 UNDERTAKER

ADDRESS

*Bernard C. Harker, 1000 S. Paca St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31111

## CERTIFICATE OF DEATH

129 E 31111  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 733 W. Chester St., 712 Ward)2-FULL NAME William Frederick Kammerer

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 733 W. Chester St. 7 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of the late Barbara Kammerer (or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept. 4 18567 AGE Years 71 Months 6 Days 23 IF LESS than 1 day...hrs. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Butcher(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER John Kammerer11 BIRTHPLACE OF FATHER (City or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Anna Feindice13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Joe Kammerer (Address) 733 W. Chester St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 192817 I HEREBY CERTIFY, That I attended deceased from September, 1927, to February 27, 1928, that I last saw him alive on February 27, 1928, and that death occurred, on the date stated above, at 2:50 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic EndocarditisCONTRIBUTORY Chronic Glomerulonephritis (Secondary) (duration) 5 yrs. mos. da.

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.What test confirmed diagnosis? Urinalysis etc(Signed) Frank J. Ayer M. D.Feb 27 1928 (Address) 2606 E Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial, Feb 19 1928Holy Redeemer Cemetery20 UNDERTAKER Kelly & Zeiler Inc. ADDRESS 403 S. Wolf St.

FEB 29 1928

R. W. E. Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31112

E 31112

## CERTIFICATE OF DEATH

71-001  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Sydenham Hospital* St. *26-37* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Eva Schantz*(a) RESIDENCE NO. *3301 Fleet St*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode) *Life*

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da.

How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year)

*Aug 4, 1927*

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min..

*0**6**25*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore Md*

10 NAME OF FATHER

*Bernard Schantz*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Balto. Md.*

12 MAIDEN NAME OF MOTHER

*Rose Young*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto. Md.*

14

Informant (Address)

*Bernard Schantz 3301 Fleet St*

15 Filed

19

C. HANDEDON JONES Registrar

EB 29 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 29 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 27, 1928, to Feb 29, 1928,*that I last saw *her* alive on *Feb 29, 1928,*and that death occurred, on the date stated above, at *10:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Infantile Convulsions Probably due to Cerebral Hemorrhage*(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *4* ds.

CONTRIBUTORY

(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

If not at place of death?

*Home*

Did an operation precede death?

*Lumbar puncture 2/28/28*

Was there an autopsy?

*No*

What test confirmed diagnosis

*Clinical & Lumbar Puncture*

(Signed)

*Myron G. Jell*

M. D.

2/29. 1928 (Address)

*Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

Date of Burial

*Sacred Heart Cmt.**Feb 29 1928*

20 UNDERTAKER

ADDRESS

*Lilly & Zuler Inc 409 So. Wolfe*



E 31113 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 341 E. 24th ST., 12-51 WARD)

2-FULL NAME Fannie Andrews

(a) RESIDENCE No. 341 E. 24th ST., 12-51 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX F. 4 COLOR OR RACE C. 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Warren Andrews

DATE OF BIRTH (month, day, and year) Jan 18 1896  
AGE Years 32 Months 0 Days 0 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

10 NAME OF FATHER Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anderson

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anderson

14 Informant Warren Andrews (Address) 341 E. 24th St.

15 8 29 1928 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1928, to Feb 26, 1928, that I last saw her alive on Feb 26, 1928, and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH\* was as follows:  
Acute Cordiac Asthma with pulmonary Edema

(duration) yrs. 2 mos. 29 ds.

CONTRIBUTORY (Secondary) Cordiac Asthma Indigestion yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam  
(Signed) G. B. Hall M. D.

, 19 (Address) 426 E 23rd St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Calvary 2/29/28  
UNDERTAKER Mrs. R. G. Elliott ADDRESS 1725 Ashland

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31114

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. \_\_\_\_\_)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

2-FULL NAME George C. Wagner(a) RESIDENCE NO. 602 S. Paca ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD \_\_\_\_\_

(If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

EX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

?

DATE OF BIRTH (month, day, and year)

AGE Years Months Days If LESS than 1 day, hrs. or min.

70

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Edw. Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14 Informant (Address)

Records

FEB 29 1928

JAMES JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28/192817 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1928, to Feb. 28, 1928, that I last saw him alive on Feb. 28, 1928, and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage -  
hemiplegia - right

(duration) yrs. mos. ds.

CONTRIBUTORY Hypertension - arterio  
(Secondary) sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sub(Signed) C. D. Williams Boyd, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Devotional Cemetery March 1928

20 UNDERTAKER

ADDRESS

McLinn & Carrow 311

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31115

## CERTIFICATE OF DEATH.

90 E 31115  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2635 Hager St. 20 Ward 14)2-FULL NAME Mary Hanzalik(a) RESIDENCE NO. 2635 Hager St. 20 Ward 14

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 0 mos. 0 ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race White5 Single, Married, Widowed, or Divorced (write the word) Married6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Joseph F. Hanzalik6 DATE OF BIRTH (month, day, and year) Jan 21 1873

## 7 AGE

Years 55Months 1Days 5IF LESS than  
1 day hrs. 0  
or min. 0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Austria

(State or country)

10 NAME OF FATHER Julius Tye11 BIRTHPLACE OF FATHER (city or town) Austria

(State or country)

12 MAIDEN NAME OF MOTHER Julia Hanzalik13 BIRTHPLACE OF MOTHER (city or town) Austria

(State or country)

## PARENTS

14

Informant  
(Address) 2635 Hager St15 Filed 23 1928

HARRISON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation(duration) Half hour yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Signed Thos B. Norton M. D.28-1928 (Address) Curtis Bay me

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Feb 29 192820 UNDERTAKER H. D. WappertADDRESS 1850 W. Calver

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31116

## CERTIFICATE OF DEATH

100-001  
E 31116  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *MD. Gen. Hospital* St., *Ward*)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *303 Howard Ave near* St. *Ward*

(Usual place of abode)

Length of residence in city or town where death occurred *63* yrs. *0* mos. *29* ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX

*Male*

4 Color or Race

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

16 DATE OF DEATH (month, day, and year)

*Feb 28, 1928*

19

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Unknown*

6 DATE OF BIRTH (month, day, and year)

*Jan 29, 1865*

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or min..

*63**0**29*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Plumber*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore*

10 NAME OF FATHER

*Harry Hill*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*England*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*

14

Informant (Address)

*Hospital Records*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 26, 1927*, to *Feb 28, 1928*, that I last saw him alive on *Feb 28, 1928*, and that death occurred, on the date stated above, at *5:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*extensive cellulitis of neck & scalp*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *7* ds.(duration) yrs. mos. *1* ds.

18 Where was disease contracted

If not at place of death?

*Unknown*

Did an operation precede death?

*yes* Date of *Feb. 26, 1928*

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Clinical*

(Signed)

, 19

*Jno. A. Thompson, M. D.*

(address)

*1159 W. Street*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Western Cemetery**Mar 2, 1928*

20 UNDERTAKER

ADDRESS

*1850 N. Carroll St*

EB 29 1928

JAMES H. L. Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31117

## CERTIFICATE OF DEATH.

E 31117

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1834 Gough St., 2-4 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1834 Gough St., \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

male

White

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28, 1928

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

1/2 hour

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. Md.  
(State or country)10 NAME OF FATHER Alexander Rydzewski11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Poland12 MAIDEN NAME OF MOTHER Sophie Woda13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Poland

14

Informant  
(Address)Alex Rydzewski  
1834 Gough St.

15

Filed

19

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

Feb. 28, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1928 to Feb. 28, 1928, that I last saw him alive on Feb. 28, 1928, and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH\* was as follows:

Still Born

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY

(Secondary)

Probable Cerebral hemorrhage

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

If not at place of death:

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? P.S.V.(Signed) John J. Knap

, 19

(Address) 2627 E. Baltimore

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Rosary Feb 29 1928

20 UNDERTAKER

ADDRESS

W. Czajewski  
1930 Eastern Ave.

311118

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 311118

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *27-43* WARD)2. FULL NAME *Emma S. Pauli*(a) RESIDENCE NO. *108 Altana Ave.* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. *90.*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *August Pauli*DATE OF BIRTH (month, day, and year) *Feb. 25 - 1860*

AGE

Years

Months

Days

If LESS than  
1 day..... hrs.  
or..... min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Home Duties*(h) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) *Baltimore Md.*10 NAME OF FATHER *Henry Thorn*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Louisa Broessel*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Germany*

14

Informant *August Pauli*  
(Address) *108 Altana Ave. Hamilton*

29 1928

19

HAMPSON JONES II

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/27/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *2/25/28*, 19, to *2/27/28*, 19, that I last saw him alive on *2/25/28*, 19, and that death occurred, on the date stated above, at *6:15 A.m.*

The CAUSE OF DEATH\* was as follows:

*chronic myocarditis*(duration) *2* yrs. *0* mos. *0* ds.CONTRIBUTORY *acute myocardial degeneration*  
(Secondary)(duration) *1* yrs. *1* mos. *7* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Lammie Fahmy*, M. D.19 (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*MOVA*  
*Sarkwood Cemetery March 3, 1928*

20 UNDERTAKER

ADDRESS

*Mr. Mrs. John W. Beffel Son 811 W. Fayette*

311119

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 311119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2912 Markley Ave. ST. 27-44 WARD)

2-FULL NAME, Helena E. Long.

(a) RESIDENCE NO. 2912 Markley

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Arthur G. Long

6 DATE OF BIRTH (month, day, and year)

March 18, 1893

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

11

9.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home Parties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Frederick Meland

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Arthur G. Long 2912 Markley Ave

15

1928

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 27, 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1928, to Feb 26th, 1928, that I last saw her alive on Feb 26th, 1928.

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 27 ds.

CONTRIBUTOR (Secondary)

Acute dilatation of heart

(duration) yrs. 1 mos. 27 ds.

18 Where was disease contracted if not at place of death?

at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical Examination

(Signed)

Harry Heibel, M. D.

(Address)

1224-26 Homers St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

March 1, 1929

UNDERTAKER

ADDRESS

Mrs. John W. Dwyer & Son 801 W. Fayette

31120

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31120

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

BALTIMORE CITY HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Emil J. Jorgensen

WARD)

(a) RESIDENCE NO. 1413

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

single

If married, widowed, or divorced HUSBAND of or WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Sweden

10 NAME OF FATHER

Emil J. Jorgensen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Sweden

12 MAIDEN NAME OF MOTHER

Caroline Jorgensen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Sweden

14

Informant (Address)

Reynolds

15

File

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26/1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1928 to Feb. 26, 1928

that I last saw him live on Feb. 26, 1928 and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH\* was as follows:

Permeious anaemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Jones, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

FEB 28 1928

Gen. Missioner Health.



31121

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31121

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. *Mercy Hospital*

ST. *2-4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Babey Lubarsky*

(a) RESIDENCE NO.

*603 S. Bond St*

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male*

*w*

*5 Married*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*2/06/25*

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

*3*

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Steve Lubarsky*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Louise Olszewski*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Poland*

14

Informant (Address)

*Steve Lubarsky 603 S. Bond St*

15

FILE

*9 1928 C. HAMMOND JONES, M. D.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 29 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*2/26/28*, 19, to *2/29/28*, 19

that I last saw him alive on *2/29/28*, 19

and that death occurred on the date stated above, at *5:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Intra cranial hemorrhage*

(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

*Forceful delivery in a contracted pelvis* (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*G. E. Winkler*

M. D.

, 19 (Address)

*Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Holy Rosary Church March 1 1928 John M. Weber 1800 Bond St*

31122

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

TY OF BALTIMORE, No. 624 Warner ST. 72-30 WARD

## 2-FULL NAME

(a) RESIDENCE No. 624 Warner ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

EX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND or (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE 50 Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

Filed

19 1928

G. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 19 28

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 19 28, to Feb 28, 19 28, that I last saw him alive on Feb 27, 19 28, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. C. M. D.

(Address) 7039 McCall St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MDVA 100 Calum St.

Feb 29 19 28

20 UNDERTAKER

ADDRESS

D. J. E. Co.

966



HEALTH DEPARTMENT—CITY OF BALTIMORE **E/31124****31124**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. **717 Willow**2-FULL NAME **Mary Elizabeth Scarborough**(a) RESIDENCE. No. **307 Berkshire**  
(Usual place of abode)Length of residence in city or town where death occurred **83** yrs. **2** mos. **29** ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD **27**WARD **27**

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

**Female****White****Widow**

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of**Widow of Geo. W. Scarborough**6 DATE OF BIRTH (month, day, and year) **12-1-1844**

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.**83****2****29**

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

**None**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)**Baltimore Md.  
Maryland**

10 NAME OF FATHER

**John Jeffers**11 BIRTHPLACE OF FATHER (city or town)  
(State or country)**Baltimore  
Maryland**

12 MAIDEN NAME OF MOTHER

**Charlotte Maddox**13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)**Baltimore  
Maryland**

14

Informant  
(Address)**J. A. Clement M. D.  
3007 Berkshire Rd.**

15

Signed

**C. HAMPTON JONES, M. D.**

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **Feb. 29 1928**

17

HEREBY CERTIFY, That I attended deceased from

**Sept**

, 1921, to

**Feb. 29**

, 1928.

that I last saw her alive on

**Feb. 29**

, 1928.

and that death occurred, on the date stated above, at **2:15** A. M.

The CAUSE OF DEATH\* was as follows:

**arterio sclerosis****probable** (duration) **6** yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed **J. A. Clement** M. D.  
(Address) **3007 Berkshire Rd.**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

**Hoodlawn Cem****Mar 2 1928**

20 UNDERTAKER

ADDRESS

**Wm J. Tucker Sons****N. Va**



31125

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31125

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3640 Morley St. ST. 10-70 WARD)2-FULL NAME William W. Dowell(a) RESIDENCE NO. 3640 Morley St. ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred 66 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(If non-resident give city or town and State)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced HUSBAND of (or) WIFE of Minnie DowellDATE OF BIRTH (month, day, and year) Aug. 22, 1861AGE 66 Years 6 Months 5 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Md.10 NAME OF FATHER Chas E Dowell11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Sarah E. Griffith13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant Mrs. Minnie Dowell  
(Address) 3640 Morley St.15 1928 C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 192817 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1928 to Feb 27, 1928, that I last saw him alive on Feb 27, 1928, and that death occurred, on the date stated above, at 19 m.  
The CAUSE OF DEATH\* was as follows:Carcinoma of stomach(duration) 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY (Secondary) metastases - general(duration) \_\_\_\_\_ yrs. 1 mos. \_\_\_\_\_ ds.18 Where was disease contracted /  
if not at place of death?Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Clinical  
(Signed) J. Frank Lutz M. D.(Address) Temple Barredis

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL New Cathedral

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Geo L. Harley1800 W. 7th St.

31126

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31126

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1041 W. Basse* ST., *21-29* WARD)2-FULL NAME *Catherine Schermann*(a) RESIDENCE NO. *1041 W. Basse* ST., *21-29* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*If married, widowed, or divorced HUSBAND of *Ernst Schermann* (or) WIFE ofDATE OF BIRTH (month, day, and year) *July 31 1858*

AGE

Years *69*Months *5*Days *27*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Mayland*10 NAME OF FATHER *Thomas Schisberg*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Theresa Schisberg*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Catherine R. Schisberg* (Address) *1041 W. Basse St.*15 Filed *1928* HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 27 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 25*, 1928, to *Feb 27*, 1928, that I last saw him alive on *Feb 26*, 1928, and that death occurred, on the date stated above, at *7:05 a* m.

The CAUSE OF DEATH\* was as follows:

*La Grippe*CONTRIBUTORY (Secondary) *Valvular Disease of Heart* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Usual*(Signed) *Ernst Schermann* M. D.(Address) *517 East M*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Cross Brooklyn*DATE OF BURIAL *3-1-28*20 UNDERTAKER *Geo A. Harley*ADDRESS *1808 W. Fayette St.*

31127

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 21 E. Woodland Ave. St. 27-56 Ward)

2-FULL NAME Charles Geller

(a) RESIDENCE NO. 21 E. Woodland Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Theresa Geller

6 DATE OF BIRTH (month, day, and year)

Nov. 23 1855

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

72

3

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired City Employee

(b) General nature of industry, business, or establishment in which employed (or employer)

Water Department

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

New York

10 NAME OF FATHER

Peter Geller

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not Known

14

Informant

W.J. Egan Geller

(Address)

5104 Belleville Ave

15 Filed

C. HAMMOND JONES, Registrar

29 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 19 28

17

I HEREBY CERTIFY. That I attended deceased from

Feb 21<sup>st</sup>, 1928, to Feb 27, 1928

that I last saw him alive on Feb 27, 1928

and that death occurred, on the date stated above, at 5.10 p.m.

The CAUSE OF DEATH\* was as follows:

Cholera - Cystitis  
Infected Gall Bladder

(duration) yrs. mos. 7 da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed)

R. C. Egan, M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery

Mar 1 1928

20 UNDERTAKER

ADDRESS

John P. Denny

715 Light St

31128

HEALTH DEPARTMENT—CITY OF BALTIMORE

31128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *26. N. Pearl* ST. *4-75* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Nunzio Raimondi*

(a) RESIDENCE NO. *26. N. Pearl*

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *25* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Domenica Raimondi*

DATE OF BIRTH (month, day, and year) *aug 5-1886*

AGE *41* Years Months *6* Days *23* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Shoe maker*

(b) General nature of industry, business, or establishment in which employed (or employer) *self.*

(c) Name of employer

9 BIRTHPLACE (city or town) *Italy* (State or country)

10 NAME OF FATHER *Antonio Raimondi*

11 BIRTHPLACE OF FATHER (city or town) *Italy* (State or country)

12 MAIDEN NAME OF MOTHER *Josephine Re*

13 BIRTHPLACE OF MOTHER (city or town) *Italy* (State or country)

14 Informant *Domenica Raimondi* (Address) *26. Pearl St.*

29 1928 *C. HAMPTON JONES, M. D.* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/28* 19*28*

17 I HEREBY CERTIFY, That I attended deceased (from *Feb 26* 19*28* to *Feb 28* 19*28* that I last saw him alive on *Feb 28* 19*28* and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Pneumonia*

CONTRIBUTORY (Secondary) *Myocardial failure* (duration) yrs. mos. *8* ds.

18 Where was disease contracted if not at place of death? *no*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Physicist's Report*

(Signed) *J. J. Swaguer* M. D.

, 19 (Address) *Res. 1735 Harford Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *new Cathedral Cemetery* DATE OF BURIAL *3/3* 19*28*

20 UNDERTAKER *Geo J Ruth* ADDRESS *1735 Harford Ave*



31129

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 E 31129

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3615 Cedar Ave ST. 13-52 WARD)

## 2. FULL NAME

Hildridge Jones McCreedy

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

3615 Cedar Ave ST. 13-52 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Etta McCreedy

DATE OF BIRTH (month, day, and year)

AGE 53 Years 4 Months 18 Days If LESS than 1 day, 0 hrs. 0 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

4 Informant (Address)

5 Filed

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 19 28

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 9, 1927 to Feb. 28, 1928that I last saw him alive about Feb. 21, 1928and that death occurred, on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH\* was as follows:

Sarcoma of left testis. Right Temporal Fossa Perithelial Angio Sarcoma. Metastasis to brain(duration) X yrs. 5 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 21 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 10, 1927Was there an autopsy? NoWhat test confirmed diagnosis? Microscopic pathology(Signed) R. Clarence Ash M. D., 19 (Address) 904 N. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Woodlawn March 2, 1928

20 UNDERTAKER

ADDRESS

Chenoweth 3615 Chestnut

31130

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31130

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL ST.

WARD)

2-FULL NAME *Harry Heck*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *3515 East Baltimore*

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*

If married, widowed, or divorced

HUSBAND of

WIFE of

*Ida*DATE OF BIRTH (month, day, and year) *7-23-86*

AGE

*41* YearsMonths *10*Days *4*

If LESS than 1 day... hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Painter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Eustaf Heck*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Margaret*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ida*

14

Informant (Address)

*Records*

15

Filed *9* 1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb-27* 1928

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 27*, 1928, to *Feb. 27*, 1928,that I last saw him alive on *February 27*, 1928,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *B. Chem. autopsy*

(Signed)

*Lyman Meigs*

M. D.

*Feb 27, 1928* (Address) *John Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Sacred Heart Cemetery**March 1<sup>st</sup>* 1928

20 UNDERTAKER

ADDRESS

*Frank V. Repetto**2818 E. Balto. St.*

31131

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31131

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 246 S. Collington Ave ST. 173 WARD)

## 2-FULL NAME

Helen M. Long (Roth)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No.

246 S. Collington Ave ST. 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

life mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

MarriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofBenjamin Long

DATE OF BIRTH (month, day, and year)

March 12<sup>th</sup> 1898

## AGE

Years

Months

Days

2911If LESS than  
1 day, hrs  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physical Instructor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Mary Young9 BIRTHPLACE (city or town)  
(State or country)Baltimore Md

## 10 NAME OF FATHER

Thomas O'Donnell

PARENTS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Ireland

## 12 MAIDEN NAME OF MOTHER

Mary Kane13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Ireland

14

## Informant

Mary O'Donnell

## (Address)

246 S. Collington Ave

15

9 1928C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28-1928

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 27, 1927, to Feb 28, 1928.that I last saw her alive on Feb 26, 1928.and that death occurred, on the date stated above, at 8:12 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma Uterine

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Geo. Heller, M. D.

19

(Address)

1937 Gough St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

New CathedralMarch 3 1928

## 20 UNDERTAKER

## ADDRESS

Frank V. Pipitone2818  
Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31132

## CERTIFICATE OF DEATH.

E 31132

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3002 Kalo Ave ST. 15-58 WARD)

2-FULL NAME Miss Elizabeth W. Burnap

(a) RESIDENCE NO. 3002 Kalo Ave ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 85 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of Single

DATE OF BIRTH (month, day, and year) Mar. 28-1842

AGE Years 85 Months 11 Days 1 If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER George A. Burnap

11 BIRTHPLACE OF FATHER (City or town) New Hampshire (State or country)

12 MAIDEN NAME OF MOTHER Harney Williams

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Miss Bertha Hiner (Address) 3002 Kalo Avenue, Baltimore

15 Filed 20 1928 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-29, 1928

17 I HEREBY CERTIFY That I attended deceased from Feb 1916 to Feb-29 1928 that I last saw her alive on Feb 28 1928

and that death occurred, on the date stated above, at 10:10 a.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Hard Palate

To my knowledge 9 yrs. mos. ds. CONTRIBUTORY Chronic Valvular Heart Disease (Secondary) To my knowledge (duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Yes

(Signed) Francis A. Carpenter, M. D.

2-29-1928 (Address) Medical Arts Building

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Greenmount Cem Mary Jenkins son

March 2 1928  
Charles  
H. Ballou



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31133

## CERTIFICATE OF DEATH.

90 E 31133

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

BALTIMORE CITY HOSPITAL

ST. \_\_\_\_\_

WARD \_\_\_\_\_

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Delia W. Jean

## (a) RESIDENCE NO. \_\_\_\_\_

(Usual place of abode)

ST. \_\_\_\_\_

WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female

colored

married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

P

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

5 4

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

Charles

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

Informant

(Address)

Records

Filed 1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2 / 26 / 28

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 23, 1928, to Feb. 26, 1928,

that I last saw her alive on Feb. 26, 1928

and that death occurred, on the date stated above, at 12:20 A. M.

The CAUSE OF DEATH\* was as follows:

Soluble pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

myocarditis, chronic

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

General Soluble

(Signed)

C. Hampson Jones M. D.

2/24/1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Laural Cem

March 1, 1928

20 UNDERTAKER

Henry To. Jenkins &amp; Sons Co

ADDRESS

Richard McCallister

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31134

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital Ward 20)2-FULL NAME Helen Page(a) RESIDENCE NO. 1509 Myrtle Ave. St.          Ward         

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleWhiteMarried

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Charles Kaiser Page

6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.About 65

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town)

(State or country)

Baltimoremd

## 10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

## PARENTS

## 14

Informant  
(Address)Mrs. Walter S. Kellum  
3205 Walbrook Ave

## 15 Filed

C. HAMPTON Jones

Registrar

1928

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 28 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry

(Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said Inquiryand that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Suicide  
Gas Poisoning Ill.CONTRIBUTORY  
(Secondary)As a result ofGas Poisoning Ill.143 108 3rd Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Buried Ridge Co

20 UNDERTAKER

Wm J. Tucker Sons

Date of Burial

Mar 14 1928

ADDRESS

North Pa

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31135

CERTIFICATE OF DEATH.

199E 31135

1-PLACE OF DEATH

City of BALTIMORE: (No. 1509 Myrtle Ave. 8-16 Ward)

2-FULL NAME Charles Kaiser Page

(a) RESIDENCE NO. 1509 Myrtle Ave. St. Ward

Length of residence in city or town where death occurred 67 yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Page

6 DATE OF BIRTH (month, day, and year) June 10, 1860

7 AGE Years 67 Months 16 Days 16 IF LESS than 1 day...hrs. or...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Louis Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schatz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

14 Informant (Address) Mrs. Walter S. Kattler 3205 Wallbrook Ave.

15 Filed... HANSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Multiple Bombs

CONTRIBUTORY (Secondary) A Look. (Duration) yrs. mos. ds. (Signed) G. O. Bladen (Coroner) M. D. 19 (Address) 143 W. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death... yrs. mos. ds. In the State... yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKEN By Fred Hodge Co. Wm. J. Tucker Sons ADDRESS 1128 N. Ave.

31136

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31136

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, NO.

613 Pennard

ST.

WARD

## 2-FULL NAME

Robert Euseby Gray

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2443 Maryland Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

77 yrs.

11 mos.

12 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Widowed

If married, widowed, or divorced

HUSBAND of (or) WIFE of

Aminie E Gray

DATE OF BIRTH (month, day, and year)

March 17-1850

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

77

11

12

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Over- President

(b) General nature of industry, business, or establishment in which employed (or employer)

Combustibles Eng

(c) Name of employer

Egyptian Co

BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

James Gray

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Anna Henderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

Informant

(Address)

Miss Minnie E. Gray  
2443 Maryland Ave

5

Filed 9-19-26, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 29 1928

17

I HEREBY CERTIFY, That I attended deceased from

Aug 1927, to Feb. 29 1928.

that I last saw him alive on Feb. 28 1928.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Prostate

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. [Signature], M. D.

429 1928 (Address)

1733 Frederick Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Cemetery

Mar 3 1928

20 UNDERTAKER

ADDRESS

J. J. [Signature]

H. P. [Signature]



31137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 31137

1-PLACE OF DEATH

TY OF BALTIMORE: (NO. Baltimore City Hospitals (No. 59 ST. 1 WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Thomas

(a) RESIDENCE No. 2210 Etting st.

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widower

If married, widowed, or divorced

HUSBAND of (or) WIFE of

Unknown

DATE OF BIRTH (month, day, and year) 1877

AGE 51 Years Months Days If LESS than 1 day. hrs. or min. 50

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Mason Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Holland,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 9-19-28 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 1928

17

I HEREBY CERTIFY, That I attended deceased from May 17, 19 27, to Feb. 23, 19 28, that I last saw him alive on Feb. 23, 19 28

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis  
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown if not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? Yes

What test confirmed diagnosis? Chemical & histology  
(Signed) L. M. Addams M. D.

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Under the earth

DATE OF BURIAL

3/1/28

ADDRESS

1218 Light

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31138

E 31138

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 4-76 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 763 N. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Bush6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. About 74

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hambury Wolf Co

## 9 BIRTHPLACE (city or town)

(State or country) Balto. Md

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

## 14

Informant (Address) Ed. H. Bush  
Gladys Wash. Korman

1928

C. HAMPTON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis with Uremia

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Broncho-pneumonia

(duration) yrs. mos. ds.

(Signed) Engelbert Zellert M. D.

(Coroner)

Address 2739 Eastern ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Oliver Date of Burial 3/2 1928

## 20 UNDERTAKER

Cook ADDRESS 502 E North Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

31139

E 31139

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 1/2 West Lombard ST WARD 18-29)

### 2-FULL NAME

Augusta Marie Pieper

### (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Gustav Pieper

DATE OF BIRTH (month, day, and year) April 16-1815

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

82

10

12

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Eichmann

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER out know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

(Address)

Miss Clara Pieper  
824 1/2 West Lombard

15

Filed

1928 HAMPSON JONES, M. D.  
R.P.W. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 14, 1928 to Feb. 29, 1928.

that I last saw him alive on Feb. 28, 1928.

and that death occurred, on the date stated above, at 20 a.m.

The CAUSE OF DEATH\* was as follows:

chronic interstitial nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed)

S. Lee Wagner

M. D.

229, 1928 (Address) 1206 E. Preston

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western Cemetery

3/3 1928

20 UNDERTAKER

ADDRESS

William Cook

502 E. North

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 31140

## CERTIFICATE OF DEATH

E 31140

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 46 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

male

COLOR OR RACE

white

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

widowed

DATE OF BIRTH

February 26, 1851

(Month)

(Day)

(Year)

AGE

77 yrs.

mos.

3 ds.

If LESS than

1 day, hrs.

or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

BIRTHPLACE

(State or country)

England

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER  
(State or country)

"

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER  
(State or country)

"

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Humes

(Address)

1908 Orleans St

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

February 29, 1978

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY. That I attended deceased from

May 25, 191 to February 29, 1978.

that I saw him alive on February 29, 1978.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Endo-myocarditis

(Duration) 10 yrs. mos. ds.

Contributory  
(SECONDARY)

General Arteriosclerosis

(Duration) unknown yrs. mos. ds.

(Signed),

Frank J. Ayer M. D.  
February 29, 1978 (Address) 2025 E. Monument St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

3/3, 1978

20 UNDERTAKER

William Cook

ADDRESS

507 E North

Hw

9 1928

C. HAMPTON JONES, JR.

REGISTRAR



31141

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO.

BALTIMORE CITY HOSPITAL

ST.

WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6 married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

1928

C. HANCOCK JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27/1928

17

I HEREBY CERTIFY That I attended deceased from

Jan. 4, 1928, to Feb. 27, 1928

that I last saw him alive on Feb. 27, 1928.

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH\* was as follows:

Acute myocardial infarction  
myocarditis, chronic  
hypertension

(duration) yrs. 3 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. J. Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS 1502

E. M. M. M. M.

E 31142

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31142

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 West Lanvale

ST. 16-27 WARD

2-FULL NAME George H. Myers

(a) RESIDENCE No. 1828 West Lanvale

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if not foreign birth?

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Lillie M. Myers

DATE OF BIRTH (month, day, and year) March 21, 1860

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

67

11

7

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) York (State or country) Pennsylvania

10 NAME OF FATHER John Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Lillie M. Myers (Address) 1828 W. Lanvale Street

15 Filed 1928 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 19 28

17

I HEREBY CERTIFY, That I attended deceased from Jan 24 1928, to Feb. 25 19 28.

that I last saw him alive on Feb. 25, 19 28, and that death occurred, on the date stated above, at 7.40 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds.

Chronic Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) George F. Shannon M. D.

2/29, 1928 (Address) 700 N. Fulton Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Lorraine Cemetery

UNDERTAKER

DATE OF BURIAL

Mar. 2, 19 28

ADDRESS 1003 W.

Baltimore St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31143

## CERTIFICATE OF DEATH.

129

E 31143

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 North Hilton

ST. WARD)

2-FULL NAME Anna E. Kramer

(a) RESIDENCE NO. 422 North Hilton

ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)  
Female White Widowed

If married, widowed, or divorced  
HUSBAND of Richard Kramer  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 2, 1848

AGE Years Months Days If LESS than 1 day, hrs. or min.  
30 - 26

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER Louis Kalling

11 BIRTHPLACE OF FATHER (city or town) Hanover  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Hanover  
(State or country) Germany

14 Informant William A. Windreth  
(Address) 422 North Hilton St.

15 AR 1 - 1928 HANCOCK JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1928

17 I HEREBY CERTIFY That I attended deceased from Feb 25, 1928, to Feb 28, 1928, that I last saw her alive on Feb 28, 1928,

and that death occurred, on the date stated above, at 1.15 Am.

The CAUSE OF DEATH was as follows:

Bright Disease

CONTRIBUTORY (duration) 2 yrs. mos. ds.  
(Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address) 1834 St. Paul Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Loudon Park Cemetery

Mar. 1, 1928

20 UNDERTAKER

1003 West Baltimore St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31144

CERTIFICATE OF DEATH.

100-082 E 31144

1-PLACE OF DEATH

City of BALTIMORE: (No.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

1928

H. JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

hereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cap. Pneumonia (duration) yrs. mos. ds.

CONTRIBUTOR (secondary) Exhaustion

(Signed) J. B. Jones M. D.

(Address) 1431 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial

20 UNDERTAKER Mrs. Jones Mar 2 1928

ADDRESS



31145

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1616 Lyall South St.* ST. *15-58* WARD)2. FULL NAME *Eva Cohen*(a) RESIDENCE No. *1616 Lyall South St.* ST. *15-58* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

*57* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 31145

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*W**Married*

If married, widowed, or divorced HUSBAND of or WIFE of

*Abraham Cohen*

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*76*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Russia*

10 NAME OF FATHER

*Jacob Sadursky*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Russia*

Informant (Address)

*Abraham Cohen 1616 Lyall South St.*

Filed

*1928**C. HAMPTON JONES, M. D. Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 29 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 1923 1928* to *Feb. 29 1928*that I last saw her alive on *Feb. 29 1928*and that death occurred, on the date stated above, at *943 p. m.*

The CAUSE OF DEATH\* was as follows:

*General Arterio-Sclerosis*(duration) *5* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(duration) *—* yrs. *—* mos. *2* ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical Findings*(Signed) *William H. Curran, M. D.*1928 (Address) *34 Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Hebrew Wash Road*

DATE OF BURIAL

*3/2/28* 19 *28*

20 UNDERTAKER

*Jack Lewis 1439 E. Pratt St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31146

## CERTIFICATE OF DEATH.

118-002  
E 31146  
REGISTERED NO.

## 1-PLACE OF DEATH

Y OF BALTIMORE: (No. *Mercy Hospital 9-47* ST. *9-47* WARD)

## 2-FULL NAME

*James Anthony Kelly*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. *807 Cator Ave* ST. *9-47* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *male* COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word)If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

*Feb 20 / 28*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*9*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Balto.*10 NAME OF FATHER *Anthony J. Kelly*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Columbus, Ohio*12 MAIDEN NAME OF MOTHER *Virginia Rice*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore*4 Informant *J. A. Kelly*  
(Address) *807 Cator Ave*

5

Filed 1-1928 19

C. HAMPTON JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/29* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from

*2/19/28*, 19 *28*, to *2/28/28*, 19 *28*that I last saw *the* *deceased* alive on *2/28/28*, 19 *28*and that death occurred, on the date stated above, at *11 PM* m.

The CAUSE OF DEATH\* was as follows:

*Intestinal obstruction*(duration) yrs. mos. *9* ds.CONTRIBUTORY  
(Secondary)*Laparotomy of Intes-*  
*tinal obstruction*  
(duration) yrs. mos. *2* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *yes* Date of *2/27/28*Was there an autopsy? *Partial autopsy*What test confirmed diagnosis? *Autopsy*  
(Signed) *J. W. Winslow*, M. D., 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral Cemetery**March 1, 1928*

20 UNDERTAKER

ADDRESS

*DeFuner - J. Ruth - 1735 Bayford Ave.*

## E 31147 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31147

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S. Collington Ave ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Smialkowski

(a) RESIDENCE NO. 218 S. Collington Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Infant

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 18-1927

AGE Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto Md (State or country)

10 NAME OF FATHER Stefan Smialkowski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Albina Drozd

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

4 Informant Stefan Smialkowski 218 S. Collington Ave (Address)

5 Filed 1919 C. H. HARTMAN, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-29-1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1928 to Feb. 29, 1928, that I last saw him alive on Feb. 29, 1928, and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho - Pneumonia

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Andrew Thompson, M. D.

459, 1928 (Address) 2529 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Rosary Cemetery UNDERTAKER

Mar 2 1928 ADDRESS

George A. Weber, 2205 Bank St

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31148

E 31148

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910. E. 30. st.

ST. 9-46 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Wahl.

(a) RESIDENCE NO. 910. E. 30. st.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos.

ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Ann Wahl.

DATE OF BIRTH (month, day, and year) Sept. 29. 1848.

AGE Years Months Days If LESS than 1 day, hrs. or min.

79

4

29

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Cigar Mfg.

BIRTHPLACE (city or town) (State or country)

Germany.

10 NAME OF FATHER

Winkham

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Augusta Wahl.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany.

14

Informant (Address)

Eduard Wahl. 910. E. 30. st.

15

Filed

1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 10, 1928, to Feb. 28, 1928.

that I last saw him alive on Feb. 28, 1928.

and that death occurred, on the date stated above, at 11:12 a m.

The CAUSE OF DEATH\* was as follows:

Paralysis  
Cerebral Paraplegia

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

Bleeding cerebral lesion

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 24 Date of —

Was there an autopsy? 24

What test confirmed diagnosis? 24

(Signed) H. G. Prentiss, M. D.

19 (Address) 634 Gramercy Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore City

March 2 1928

20 UNDERTAKER

ADDRESS

George - J. Rutter 1735 Hayford Ave.



E 31149

HEALTH DEPARTMENT—CITY OF BALTIMORE E 31149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3170 Ravenswood Ave. 8-40 WARD)

2-FULL NAME

Barbara Kridel

(a) RESIDENCE NO. 3170 Ravenswood ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

Late Jacob Kridel

DATE OF BIRTH (month, day, and year) Mar 3 18 57

AGE 70 Years 3 Months 25 Days If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

Jacob Kridel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Barbara Kridel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt

14

Informant (Address)

Frank Kridel 3170 Ravenswood Ave

15

Filed

1920 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 1926 to Feb 28 1928 that I last saw her alive on Feb 27 1928 and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH\* was as follows:

Myo + Endo Carditis

To my knowledge (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart specimen (Signed) Dr. M. D.

(Address) 301 S Ellwood St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Carmel Cemetery

3 2 1928

20 UNDERTAKER

ADDRESS

George F. Ridd 1735 Maryland Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31150

## CERTIFICATE OF DEATH.

E 31150

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St. Joseph's Hospital* ST. *77-44* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Cecilia Dressel*(a) RESIDENCE NO. *39 E. Hamilton Ave* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_(If non-resident give city or town and State) How long in U. S., if of foreign birth? *life* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of \_\_\_\_\_ (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *1903*AGE *24* Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *C + P*(b) General nature of industry, business, or establishment in which employed (or employer) *Clerk*(c) Name of employer *C + P*BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) *Baltimore*10 NAME OF FATHER *John Dressel*11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Francis Hildeman*13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) *Baltimore*Informant *John Dressel* (Address) *13202 E. Hamilton Ave*Filed *1-19-28*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/28/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *2/26/28*, 19, to *2/28/28*, 19, that I last saw her alive on *2/28/28*, 19, and that death occurred, on the date stated above, at *11:45 A. m.*

The CAUSE OF DEATH\* was as follows:

*pulmonary tuberculosis*(duration) *1* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY (Secondary) *pulmonary hemorrhage*(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *H. Lawrence Kennedy*, M. D., 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Redeem Church*DATE OF BURIAL *March 2 1928*20 UNDERTAKER *W. J. Ruth*ADDRESS *1735 Hayford Ave*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31151

## CERTIFICATE OF DEATH.

89 E 31151

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 St. Paul ST. 12 WARD)

### 2-FULL NAME

Mary Jane Wolfe

(a) RESIDENCE NO. 1931 St. Paul ST. 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. ? mos. ?

How long in U. S., if of foreign birth? 70 yrs. ? mos. ?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Resident

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

If married, widowed, or divorced HUSBAND or (or) WIFE of Francis E. Wolfe

DATE OF BIRTH (month, day, and year) About 1858

AGE Years Months Days If LESS than 1 day, hrs. or min. About 70 - ? - ?

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

10 NAME OF FATHER James Reaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catharina McWhorter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14

Informant Mr. Eugene Wolfe (son) (Address) Baltimore, Md.

Filed 1928 Registrar R. H. H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1928, to Feb. 29, 1928.

that I last saw him alive on Feb. 28, 1928

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) 1 hour yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure & ECG (Signed) Charles G. G., M. D.

19 Address 1111 W. Carroll St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Loudon Park DATE OF BURIAL Mar 2, 1928

20 UNDERTAKER Stewart Monahan ADDRESS Balto.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31152

## CERTIFICATE OF DEATH.

E 31152

1-PLACE OF DEATH *Church Home & Infirmary*  
CITY OF BALTIMORE: (No. *106 N. Broadway* ST. *6-9* WARD)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2-FULL NAME *Mrs. Mary Flaherty*(a) RESIDENCE NO. *Sausdale Pk.* ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred yrs. mos. *10* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced HUSBAND of (or) WIFE of *Charles J. Flaherty Jr.*DATE OF BIRTH (month, day, and year) *Feb 18 - 1888*AGE Years *40* Months *X* Days *12* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Pa.*10 NAME OF FATHER *Wm J Brown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Pa*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*14 Informant *Charles J. Flaherty*  
(Address) *Sausdale Pa*15 *HAMPSON JONES, M. D.*  
Filed *1928* Registrar *R. H. Jones*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/1/1928*17 I HEREBY CERTIFY, That I attended deceased from *2/21/28* to *3/1/28*, that I last saw him alive on *3/1/28*, and that death occurred, on the date stated above, at *2.20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Acute exsanguination of chronic nephritis during pregnancy*(duration) yrs. mos. *12* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *2* ds.18 Where was disease contracted if not at place of death? *Sausdale, Pa*Did an operation precede death? *No* Date of *2/25/28*Was there an autopsy? *No* *therapeutic abortion*What test confirmed diagnosis? *Physical findings - Laboratory tests etc*(Signed) *J. Frank Hewitt*, M. D.*3/1/28* (Address) *Church Home & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Sausdale Pa.**March 1928*

20 UNDERTAKER

ADDRESS

*Myer & Jones, Inc. 44 N Broadway*



E 31153

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31153

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 408 N. Durham St. 6-9 Ward)

Registered No. ....

## 2-FULL NAME

Joshua Hutchins

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) Residence No.

408 N. Durham

St. .... Ward. ....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS.

## SEX.

Male

## 4-COLOR OR RACE,

Col

## 5-Single,

Married, Widowed, or Divorced, (Write the word.)

If married, widowed, or divorced

HUSBAND of (or) WIFE of Annie Hutchins

DATE OF BIRTH (month, day and year) Not known

## AGE.

71 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

## OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

E. J. Gallagher

BIRTHPLACE (city or town) (State or Country)

Eastern Shore Md

## 10-NAME OF FATHER,

Jervis Hutchins

## 11-BIRTHPLACE

OF FATHER (city or town) (State or Country)

Eastern Shore Md

## 12-MAIDEN NAME OF MOTHER,

Not known

## 13-BIRTHPLACE

OF MOTHER (city or town) (State or Country)

Eastern Shore Md

## 11-

(Informant) Charles Hutchins

(Address) 1113 W. Mulberry St

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2-28-28

17- I HEREBY CERTIFY, That I attended deceased from Feb 14, 1928, to Feb 28, 1928,

that I last saw him alive on Feb 27, 1928,

and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

2-29, 1928 (Address) J. E. Thomas, M. D. 822 N. Bond St.

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

Asbury cemetery

DATE OF BURIAL

Mar 2, 1928

20-UNDERTAKER,

Edward Bryan

ADDRESS

1631

11-

Filed

1928

HAMILTON JONES, M. D.

Registrar.

E 31154

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31154

## CERTIFICATE OF DEATH.

101-001

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 W Bare

ST. 22-31 WARD)

## 2. FULL NAME

Bessie Bell

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

614 W, Bare

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

16 yrs. 9 mos. 5 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

Cot

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

May 23/1901

AGE

Years

16

Months

9

Days

5

If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Dartmouth Maryland

10 NAME OF FATHER

Peyton Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mt Ellis Hills Maryland

12 MAIDEN NAME OF MOTHER

Laura Swalls

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Carroll Co Maryland

Informant (Address)

William Williams 614 W Bare

AR 1 - 1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/28 1928

17

I HEREBY CERTIFY, That I attended deceased from

2/24 1928, to 2/28 1928,

that I last saw him alive on

2/27 1928

and that death occurred, on the date stated above, at

3:00 p. m.

The CAUSE OF DEATH\* was as follows:

acute Sobar pneumonia

(duration) — yrs. — mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dan J. Anderson, M. D.

1/27/28 (Address) 122 W Bare

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

Dan J. Anderson

March 1 1928  
ADDRESS 916 Bare

E 31155

HEALTH DEPARTMENT-CITY OF BALTIMORE

129 E 31155

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Pondent Hospital

REGISTERED NO.

City of BALTIMORE: (No.

St. 14-20 Ward)

2-FULL NAME

Christina Harris Robinson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

608 Maple

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. da.

How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

cre

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mount Robinsons

6 DATE OF BIRTH (month, day, and year)

1879

7 AGE

49

Years

Months

Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

md

10 NAME OF FATHER

Richard Harris

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

md

12 MAIDEN NAME OF MOTHER

Edith Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md

14

Informant (Address)

Mount Robinson 608 Maple St

15 Filed

1928

HAMPTON JOY Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2-28-28

17

I HEREBY CERTIFY, That I attended deceased from

2-23, 1928, to 2-28, 1928

that I last saw her alive on 2-27, 1928

and that death occurred, on the date stated above, at 8a

The CAUSE OF DEATH\* was as follows:

Cardiovascular Renal

(duration) yrs. mos. da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis? clinical

(Signed) W. B. Butler M. D.

19 (Address) 428 N. Linden St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

md Calver Green

March 1, 1928

20 UNDERTAKER

Mount Easton

ADDRESS 916

Be ab

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31156

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 639 N. Robinson ST., 7-11 WARD)

2-FULL NAME Charles E. Busch

(a) RESIDENCE No. 639 N. Robinson ST., WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 44 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? 43 mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of Anna C. Busch WIFE of

DATE OF BIRTH (month, day, and year) Dec. 10, 1883  
AGE Years 44 Months 2 Days 18 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing trimmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Philip Kahr

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Joseph E. Busch

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Kahr

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Joseph E. Busch (Address) 639 N. Robinson St.

15 R 1-1928 HANSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1928, to Feb. 28, 1928, that I last saw him alive on Feb. 28, 1928, and that death occurred, on the date stated above, at 9:57 p. m.

The CAUSE OF DEATH\* was as follows: Lobar Pneumonia

(duration) yrs. mos. 5 ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Vincent V. Joske, M. D. 2/29, 1928 (Address) 845 W. Patterson Pl. Eop

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Partwood Cemetery Harry Beck Son

March 3, 1928 1301 E. Eager



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31157

CERTIFICATE OF DEATH.

129 E 31157

1-PLACE OF DEATH

City of BALTIMORE: (No. 1705 Gorsuch Ave St., 9-46 Ward)

2-FULL NAME

Joseph A. Lawrence

(a) RESIDENCE NO.

1705 Gorsuch Ave

St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. - 14 mos.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 14 yrs. 14 mos. 14 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

male

4 Color or Race

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

6 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

7 DATE OF BIRTH (month, day, and year)

Feb 9/1971

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

57

0

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Iron Molder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER

Phillip J Lawrence

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto., Md.

12 MAIDEN NAME OF MOTHER

Mary Trunk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant  
(Address)

Aloysius Lawrence

1627 Homestead St

15 Filed

MAR 1 - 1928

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 29/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry  
(Inquest, autopsy or inquiry.)

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chr. Myocarditis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Chr Nephritis Arthritis  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) J. J. O'Connor M. D.

(Coroner)

(Address)

3/1/28

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cemetery March 3 1928

20 UNDERTAKER

ADDRESS

Henry Stock 1301 E Eager St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31158

## CERTIFICATE OF DEATH.

E 31158

PLACE OF DEATH

OF BALTIMORE: (No. *Baltimore City Hospital*)FULL NAME *George S. Norris*RESIDENCE NO. *E. Maguire*

(Usual place of abode)

Length of residence in city or town where death occurred

ST. *Mc*

WARD

(If non-resident give city or town and State)

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*n**white**Widowed*married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

1-1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-28* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from  
*2-16* - 19 *28*, to *2-28*, 19 *28*  
that I last saw him alive on *2-28*, 19 *28*  
and that death occurred, on the date stated above, at *4:08* p.m.

The CAUSE OF DEATH was as follows:

*Chronic Sublethral Nephritis,  
Benign Prostatic Hypertrophy,  
Chronic Urinary Retention*CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date of -Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *James S. Norris* M.D.19 (Address) *Baltimore City Hospital*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## 3/1/59 HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ E 31159

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital,  
CITY OF BALTIMORE: (No. Baltimore, Maryland

ST. 2-4 WARD

REGISTERED NO. 38 E 31159  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

2-FULL NAME Ganiotis, Costas

(a) RESIDENCE NO. 750 S. Broadway  
(Usual place of abode)Length of residence in city or town where death occurred 5 yrs. 7 mos. 22 ds. ST. WARD  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 10 yrs. 7 mos. 22 ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white 5 Single, Married, Widowed,  
or Divorced, (write the word) singleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 28, 1893

AGE Years Months Days If LESS than  
34 6 2 1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Seaman(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Oiler

(c) Name of employer SS William A. McKenney

BIRTHPLACE (city or town) Greece  
(State or country)

10 NAME OF FATHER Vaganos Ganiotis

11 BIRTHPLACE OF FATHER (city or town) Greece  
(State or country)

12 MAIDEN NAME OF MOTHER Argata Marinaki

13 BIRTHPLACE OF MOTHER (city or town) Greece  
(State or country)14 Informant Records of Marine Hospital  
(Address)15 Filed 1928 C. HANCOCK JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 19 28

I HEREBY CERTIFY, That I attended deceased from  
Sept. 7, 19 28, to Feb. 28, 19 28.that I last saw him alive on February 28, 19 28,  
and that death occurred, on the date stated above, at 7:35 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis, chronic, active

(duration) 5 yrs. mos. ds.  
CONTRIBUTORY Syphilis, primary & secondary  
(Secondary)(duration) yrs. 10 mos. ds.  
18 Where was disease contracted  
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum exam. &amp; X-ray

(Signed) M. S. Main M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 31160

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31160

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 N. Lakewood Ave

ST.

WARD)

2-FULL NAME Christian W. Kraft

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 14 N. Lakewood Ave.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of Emma V. Kraft

DATE OF BIRTH (month, day, and year) Sept. 26th. 54

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	0	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Contractor

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country)

10 NAME OF FATHER Christopher Kraft

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Geiger

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) GermanyInformant  
(Address)Emma V. Kraft  
14 N. Lakewood Ave.

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28th. 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 1926, to Feb. 28, 1928.

that I last saw him alive on Feb. 28, 1928.

and that death occurred, on the date stated above, at 10.20 P.M.

The CAUSE OF DEATH\* was as follows:

angina - (coronary thrombosis)  
 cardio-vascular - renal disease -  
 chr. nephritis - arterial sclerosis & venous -

(duration) 10 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Emphysema &amp; chr. Bronchitis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy. exam -

(Signed) Louis F. Krumm M. D.

19 (Address) 722 N. Kenwood ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Lorraine Cem.

DATE OF BURIAL

3/2/28,

ADDRESS

20 UNDERTAKER

Philip Henry 2016 Orleans St.



# HEALTH DEPARTMENT - CITY OF BALTIMORE

## CERTIFICATE OF DEATH

**E 31161**  
1-PLACE OF DEATH

129 **E 31161**  
REGISTERED NO.

City of BALTIMORE: (No. 1902 Edmondson 46-27 Ward)

2-FULL NAME Virginia Lee Gardshell

(a) RESIDENCE NO. 1902 Edmondson St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 19 1/2 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 3, 1868

7 AGE Years 60 Months 1 Days 26 IF LESS than 1 day... hrs. or... min..

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

None

9 BIRTHPLACE (city or town) Balto (State or country) MD

10 NAME OF FATHER Frederick Gardshell

11 BIRTHPLACE OF FATHER (City or town) Balto, Md (State or country)

12 MAIDEN NAME OF MOTHER Victorine Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md (State or country)

14 Informant Mrs Florence G. Ramey (Address) 1902 Edmondson St.

15 Filed 1928 19 C. HAMPTON Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/29 19 28

17 I HEREBY CERTIFY, That I attended deceased from May 31, 19 24, to Feb 28, 19 28, that I last saw her alive on Feb 28, 19 28, and that death occurred, on the date stated above, at 12 45 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank H. Baker M. D.

2/29 1928 (Address) 3005 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park Cemetery Feb 2 19 28  
20 UNDERTAKER for Frederickson & Son ADDRESS 2178 Pen

HEALTH DEPARTMENT—CITY OF BALTIMORE

31162

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 14-27 Ward)

2-FULL NAME

(a) RESIDENCE NO. 314 N. Strickers St. Ward

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race Black 5 Single, Married, Widowed, or Divorced, (write the word) Single

6 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE 15 Years 16 Months 7 Days IF LESS than 1 day.....hrs. or.....min. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at school  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

10 NAME OF FATHER Clarence Krillan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Agnes Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14

Informant  
(Address)

Hospital Record

15 Filed

1928

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb - 28 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Operation for fistula in ano

CONTRIBUTORY (Secondary) Ether anaesthesia

(Signed) Reginald J. Miller M. D.  
(Coroner)

Address 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 314 N. Strickers St.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn Cemetery

Date of Burial

Mar. 2, 1928

20 UNDERTAKER

Mrs Kate R. Williams

ADDRESS

322 N. Schroeder St

E 31163

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31163

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Volunteer of America Hospital*  
 CITY OF BALTIMORE: (No. *418 W. Lexington St.* WARD *11-7*)

REGISTERED NO. *90*  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Goerge Culberson*  
 (a) RESIDENCE NO. *608 North Calvert St.* ST. *11* WARD *11*

(Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*  
 If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *7*  
 AGE Years Months Days *57* years. If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Musician*  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

BIRTHPLACE (city or town) *Baltimore Md.* (State or country)

10 NAME OF FATHER *J Wesley Culberson*  
 11 BIRTHPLACE OF FATHER (city or town) *Baltimore Md* (State or country)  
 12 MAIDEN NAME OF MOTHER *Annice McElroy*  
 13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md* (State or country)

14 Informant *Wm & Karl* (Address) *Harford Road & Forrest Ave*

15 *C. HAMPSON JONES, M. D.* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 29<sup>th</sup> 1928*

17 I HEREBY CERTIFY, That I attended deceased from *2-24* 19 *28*, to *2-28* 19 *28*, that I last saw him alive on *2-29* 19 *28*, and that death occurred, on the date stated above, at *11* *A* m.

The CAUSE OF DEATH\* was as follows:  
*Pneumonia*

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) *Mr. Myocarditis* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *2*

Did an operation precede death? *No* Date of \_\_\_\_\_

Was there an autopsy? *No*

What test confirmed diagnosis? *Phys. & Lab.* (Signed) *J. H. Jones, M. D.* 2-29-28 (Address) *2214 E. Fayette*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Greenmount Cemetery* DATE OF BURIAL *Mar 2<sup>nd</sup> 1928*

20 UNDERTAKER *George & William & Sons* ADDRESS *1208 Mount St*

1928

31164

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 31164

## CERTIFICATE OF DEATH.

### 1. PLACE OF DEATH

TY OF BALTIMORE: (NO. *Franklin Square Hosp. ST. 18-29* WARD)

2. FULL NAME *Mrs Anna May Burke.*

(a) RESIDENCE NO. *106 Scott Street.*

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced. (write the word)

*Female White Married*

If married, widowed, or divorced

(or) WIFE of *Frederick Burke.*

DATE OF BIRTH (month, day, and year) *July 27 - 1888*

AGE Years Months Days If LESS than 1 day, hrs. or min.

*34 7 3*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *house work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Baltimore*

10 NAME OF FATHER *Adam Doff*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*

12 MAIDEN NAME OF MOTHER *Elizabeth Edelberger* (Address) *Franklin Square Hosp.*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant (Address) *Hospital Records.*

15 *1928* C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-1-28* 19

17 I HEREBY CERTIFY, That I attended deceased from *2-4-28* 19 to *3-1-28* 19

that I last saw him alive on *3-1-28* 19

and that death occurred, on the date stated above, at *6:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Generalized Peritonitis (Ruptured Appendix) Intestinal Obstruction*

(duration) yrs. mos. *20* ds.

CONTRIBUTORY (Secondary) *Myocardial Infarction*

(duration) yrs. mos. *5* ds.

18 Where was disease contracted if not at place of death? *Home.*

Did an operation precede death? *Yes* Date of *2-4-28*

Was there an autopsy?

What test confirmed diagnosis? *Clinical* (Signed) *Cecil M. Hall* M. D.

(Address) *Franklin Square Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Schwarzly Beer*

*Nov 3<sup>rd</sup> 1928*

UNDERTAKER

ADDRESS

*John J. Leonard & Son, 90 N. Hollins St.*



31165

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Cariden Station 28-63 Ward)

2-FULL NAME James C. Hessenauer

(a) RESIDENCE NO. 4416 Groveland Ave. St. 170 Ward 6

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith K. Hessenauer

DATE OF BIRTH (month, day, and year) August 15, 1900.

AGE Years 27 Months 6 Days 14 IF LESS than 1 day.....hrs. or.....min.

5 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) Welfare Dept.

(c) Name of employer B. & O. Railroad Co.,

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Peter Hessenauer

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Unknown. (State or country)

14 Informant Edith K. Hessenauer (Address) 4416 Groveland Ave.,

15 Filed C. HAMPSON JONES, M. D. Registrar 1928

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, au-

Inquiry and that said deceased came to his death (Inquest, au-

topsy or Inquiry.)

on the day stated above. The CAUSE OF DEATH\* was as follows:

Revolver wound of head.  
Suicide.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) Eugene Zeller M. D. (Coroner)

2/29/1928 (Address) 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Ridge Cemetery 3/3 1928  
Chas. P. Warr Hon. J. H. Royce  
me

31166

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31166

## CERTIFICATE OF DEATH.

REGISTERED NO. 111-002

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *72-30* WARD)2-FULL NAME *Harry C. Robey*(a) RESIDENCE NO. *609 W. Baire* ST.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *May 20-1887*AGE *40* Years Months *9* Days *11* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Balto Ind*10 NAME OF FATHER *Nicholas Robey*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Ind*12 MAIDEN NAME OF MOTHER *Eliy E. Wille*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Ind*4 Informant (Address) *Mrs. E. C. Robey 609 W. Baire Street*5 - 1928 C. HAMPTON JONES, M. D. Registrar *RKH*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/1/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*2-28-28*, 19, to *3-1-28*, 19,that I last saw him alive on *3-1-28*, 19,and that death occurred, on the date stated above, at *5:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Perforated duodenum**48 hrs* (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*24 hrs* (duration) yrs. mos. *48 hrs*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *2-28-28*Was there an autopsy? *no*What test confirmed diagnosis? *operation*(Signed) *L. U. Lumphkin*, M. D.3/1, 1928 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Frederick Co. Md.**2/5 1928*

20 UNDERTAKER

ADDRESS

*William Cook**502 E. North*

HEALTH DEPARTMENT - CITY OF BALTIMORE

E 31167

CERTIFICATE OF DEATH

129 E 31167

1-PLACE OF DEATH

City of BALTIMORE: (No. 2410 N. Calvert St. 17-50 Ward)

2-FULL NAME Marmaduke Hamilton

(a) RESIDENCE NO. 2410 N. Calvert

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs.  mos.  ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud Hamilton

DATE OF BIRTH (month, day, and year) Oct 20 1858

7 AGE Years 69 Months 4 Days 8 IF LESS than 1 day.....hra. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West River  
(State or country) A. A. Co. Md

10 NAME OF FATHER Samuel Hamilton

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Inwall

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14 Informant Maud Hamilton (wife)  
(Address) 2410 N. Calvert St

15 Filed 1928 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1928

17 I HEREBY CERTIFY, That I attended deceased from January 11, 1928, to Feb 28, 1928, that I last saw him alive on Feb 28, 1928

and that death occurred, on the date stated above, at 10 55 P. M.

The CAUSE OF DEATH\* was as follows: Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Myocardio insufficiency

18 Where was disease contracted

If not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physic signs, urinal

(Signed) W. H. Harrison, M. D.

19 (Address) 2437 N. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Cemetery

20 UNDERTAKER

John F. Denny

Date of Burial

Mar 2 1928

ADDRESS

715 Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

31168

CERTIFICATE OF DEATH

101-001  
E 31168

1-PLACE OF DEATH

City of BALTIMORE: (No. 215 N. Monument St. 11-25 Ward)

2-FULL NAME

Lottie F. Parsons

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

215 N. Monument St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 da. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 da.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female white

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

1858?

7 AGE

Years

Months

Days

IF LESS than 1 day...hrs. or...min..

70?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Princess Anne

(State or country)

Md

10 NAME OF FATHER

Refus M. Parsons

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant

(Address)

Mrs. W. F. Debeling  
4409 Springdale Ave.

15 Filed

C. HAMMOND JONES, M. D.

Registrar

1928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 1 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 28, 1928, to Mar. 1, 1928,

that I last saw her alive on Feb. 29, 1928,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Pneumonia lobar

(duration) 3 yrs. 0 mos. 3 da.

CONTRIBUTORY

(Secondary)

Cardiac dilatation

(duration) 2 yrs. 0 mos. 2 da.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. H. C. Blake, M. D.

3/1. 1928 (Address) 719 Med. Bldg.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Princess Anne Md

3/2 1928

20 UNDERTAKER

Henry J. Jenkins & Sons Co

ADDRESS

McClure St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31169

31169

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Washington Ave* ST., *27-54* WARD)2. FULL NAME *Sister Maryloysine Ady*(a) RESIDENCE NO. *St Agnes Convent Washington Ave* ST., *27* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *54* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female*4 COLOR OR RACE *white*5 Single, Married, Widowed, or Divorced, (write the word) *Single*If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*DATE OF BIRTH (month, day, and year) *Aug 14, 1856*

AGE

Years

Months

Days

If LESS than 1 day,.....hrs. or min.

*71**7**15*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Religious* *065*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Sisters of Mercy*9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *Edward Ady*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*12 MAIDEN NAME OF MOTHER *Henrietta Wheeler*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14

Informant (Address) *Sister M. Carmelita*  
*Convent St. Agnes West Washington*

15

Filed *1928*

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 29 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 23* to *July 29* 1928, that I last saw her alive on *July 29* 1928and that death occurred, on the date stated above, at *90* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*(duration) *5* yrs. *0* mos. *0* ds.CONTRIBUTORY (Secondary) *Pneumonia*(duration) *0* yrs. *0* mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *1*Was there an autopsy? *no*What test confirmed diagnosis? *Physical symptoms*(Signed) *William J. Hall*

M. D.

19 (Address) *St Washington*

\*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St Agnes Mt Washington*

DATE OF BURIAL

*Mar 3rd 1928*

20 UNDERTAKER

*Larry H. Jenkins Bros Co*

ADDRESS

*McClulloch + Orchard*

31170

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31170

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N. Caroline ST. 5-9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 13 mos.

ds. How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, ... hrs.  
or ... min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

5

1928

19

C. HAMMOND JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 25, 1928, to Feb. 29, 1928.  
that I last saw him alive on Feb. 29, 1928  
and that death occurred, on the date stated above, at 7 A. m.  
The CAUSE OF DEATH\* was as follows:

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)  
(duration) yrs. mos. ds.  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Rabey J. Green, M. D.

3-1, 1928 (Address) 120 Disquith St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 31171

E 31171

## CERTIFICATE OF DEATH.

-PLACE OF DEATH

Y OF BALTIMORE: (No. *Balti City Hospital* 17-76 ST. WARD)-FULL NAME *Henry Curtis*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

a) RESIDENCE NO. *525 Borne*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

*70* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *White Cal.* 5 Single, Married, Widowed, or Divorced, (write any word) *married*married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *Jan 14 1928*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER *Peter Curtis*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Anna Seymour*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)*Anna Garmes*  
*525 Borne St*

Filed

1928

C. HAMMOND JONES, M. D.  
*R. H. Jones* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-29-28*

17

I HEREBY CERTIFY, That I attended deceased from  
*Jan 14*, 19*28*, to *Feb. 29*, 19*28*  
that I last saw him live on *Feb. 29*, 19*28*

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*Generalized arteriosclerosis  
Chronic myocarditis. Frost  
bite of right femur (accident)  
fall* (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY  
(Secondary)*Brucella Brucellae*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *2* ds.18 Where was disease contracted  
if not at place of death? *Home*Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *burned leg*(Signed) *R. H. Jones* M. D., 19 (Address) *Balti City Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Mt. Auburn**Mar 3 1928*

20 UNDERTAKER

ADDRESS *1027**John H. Toadman**Kenned Hill*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31172

PLACE OF DEATH

Y OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)married, widowed, or divorced  
Husband of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

WARD)

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Nov 15, 1927, to Feb 27, 1928,  
that I last saw her alive on Feb 25, 1928,  
and that death occurred, on the date stated above, at 8<sup>10</sup> P. m.  
The CAUSE OF DEATH\* was as follows:Carcinoma Breast (left)  
(operation Sept. 1927)CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

2/28/28

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ E 31173

31173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *17-50* St. *Walsh* Ward)

2-FULL NAME

(a) RESIDENCE NO. *2725 - N. Calvert*

(Usual place of abode)

Length of residence in city or town where death occurred *48* yrs. *5* mos. *12* ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced. (write the word) *Married*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of *Katherine B. Walsh*

7 DATE OF BIRTH (month, day, and year) *Sept 17 1879*

AGE Years *48* Months *5* Days *12* IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Contractor*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Building*  
(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)

10 NAME OF FATHER *James Walsh*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore*  
(State or country)

12 MAIDEN NAME OF MOTHER *Eugenia Gardner*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore*  
(State or country)

14 Informant *Katherine Walsh*  
(Address) *2725 - N. Calvert*

15 *MAR 2 - 1928* 16 *C. HARRISON JONES, M.D.*

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 1 1928*

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

Whereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *this* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Heart Disease*  
*Some years* (duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) *Heart Disease* (duration) .....yrs. ....mos. ....ds.  
(Signed) *E. J. Jones* M. D.  
(Coroner)  
1928 (Address) *1637 Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.  
Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Cathedral Cemetery* 3/3 1928

20 UNDERTAKER

*Henry W. Mears & Son* 805 N. Calvert St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1174

CERTIFICATE OF DEATH.

80 E 31174

1-PLACE OF DEATH

City of BALTIMORE

2-FULL NAME

(a) RESIDENCE NO.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry,

thereon and from the evidence obtained by said inquest, autopsy or inquiry,

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Coronary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

18 ADDRESS

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31175

## CERTIFICATE OF DEATH.

E 31175

PLACE OF DEATH

REGISTERED NO.

OF BALTIMORE: (No. 1310 N. Carey St. 15-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

RESIDENCE NO. 1310 N. Carey St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## CORONER'S CERTIFICATE OF DEATH

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE 57 Years 11 Months 27 Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employerBIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)AR 2 - 1928 HARRISON JONES, M.  
Registrar

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Stenosis  
E. Kaustine (duration) mos. — ds.  
CONTRIBUTORY (Secondary) G. C. Blades (duration) yrs. mos. — ds.  
M. D. 1/28 (Address) 145 76 73rd

\* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

FUNERAL UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

31176

CERTIFICATE OF DEATH.

31 E 31176  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colomach Hospital St. 16-72 Ward)

2-FULL NAME Maggie Briscoe

(a) RESIDENCE NO. 1119 Vincent St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race Col 5 Single, Married, Widowed, or Divorced. (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Jacksonale Briscoe

DATE OF BIRTH (month, day, and year) June 1888

AGE Years 40 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Ind (State or country)

10 NAME OF FATHER Ind

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country)

12 MAIDEN NAME OF MOTHER Ind

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country)

14 Informant Charles Briscoe (Address) 1119 Vincent

15 Filed 1928 HARRISON JONAS, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry and that said deceased came to hor death on the day stated above.

The CAUSE OF DEATH\* follows:

Full TB

CONTRIBUTORY (Secondary)

(Signature) Exhaustion (date) 7 mos. 7 ds. (Signature) Blades (date) 1 mos. 1 ds. M. D. 1/28 (Address) 1436 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL McAuburn Date of Burial Mar 4 1928

20 UNDERTAKER Sam H. Chase ADDRESS 1456 Madison



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31177

## CERTIFICATE OF DEATH.

165 E 31177

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *13-59*)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced; (write the word)

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 5 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

2-1928

H. H. JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I took charge of the remains described above, held an  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31178

PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Cherry Street 25-75 ST. WARD)

FULL NAME James Brosar

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

RESIDENCE NO. 12 Cherry Street

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds.

ST. WARD

How long in U. S., if of foreign birth? 39 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

HUSBAND of (or) WIFE of Anna Brosar

DATE OF BIRTH (month, day, and year) Sept 26 1863

AGE 64

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retire

(b) General nature of industry, business, or establishment in which employed (or employer) Street Dep.

(c) Name of employer City

BIRTHPLACE (city or town) (State or country) Bohemia

10 NAME OF FATHER James Brosar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Sophia Cernak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

Informant Anna Brosar

(Address) 12 Cherry Street

Filed 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1928

17

I HEREBY CERTIFY, That I attended deceased from  
 Feb 22 1928, to 3/1/28 12 am 1928  
 that I last saw him alive on Feb 1 1928  
 and that death occurred, on the date stated above, at 145 A m.

The CAUSE OF DEATH\* was as follows:

Nephritis, pyelonephritis, Chr.

CONTRIBUTORY (duration) 1 yrs. mos. ds. Same

18 Where was disease contracted (duration) 1 yrs. mos. da. Same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. (Signed) Robert W. Johnson M. D.

19 (Address) Brooklyn

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Cross Cemetery

UNDERTAKER

August Pasch

DATE OF BURIAL

March 5 1928

ADDRESS

2406 Ashland Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31179

## CERTIFICATE OF DEATH.

129E 31179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

4414 Kathlamet St.

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Selma H. Webster

Residence in Baltimore: No.

4414 Kathlamet St.

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX,

male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

DATE OF BIRTH,

Oct. 29, 1855

(Month)

(Day)

(Year)

AGE,

72 yrs. 4 mos. ds.

If LESS than 1 day,

hrs. or min.

OCCUPATION:

(a) Trade, profession, or particular kind of work.

Home

(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE, (State or Country),

Blyton Park N. Y.

10-NAME OF FATHER,

Matthew Vandercook

11-BIRTHPLACE OF FATHER (State or Country),

Blyton Park N. Y.

12-MAIDEN NAME OF MOTHER

Elizabeth Hines

13-BIRTHPLACE OF MOTHER (State or Country),

N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Zoe Elizabeth Ostrom

(Address)

4414 Kathlamet St.

15-

R 2 - 1928

C. HAMMOND JONES, M. D.

191

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb. 29, 1928

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 24 1928, to Feb 29 1928,

that I saw her alive on

Feb 29 1928,

and that death occurred, on the date stated above, at 9:15 p. m.

The CAUSE OF DEATH\* was as follows:

Bronchitis - Pneumonia (Hypertensive)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thomas H. Warner, M. D.

Feb 29, 1928 (Address) 2644 Garrison St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Groy N. Y.

Mar 2, 1928

20-UNDERTAKER

ADDRESS

Wm J. Pickner Sons

N. Y. &amp; Pa

31180

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129E 31180

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 W. North Ave., ST. 15-21 WARD)

FULL NAME Sarah Leah Glasser

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1802 W. North Avenue ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

married, widowed, or divorced

HUSBAND of  
or) WIFE of Nathan Glasser

DATE OF BIRTH (month, day, and year)

AGE Years Months Days If LESS than 1 day, hrs. or min.  
72

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) Russia

10 NAME OF FATHER Karl Heller

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie ----

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Russia4 Informant Harry Glasser  
(Address) 1802 W North Ave

5 Filed 1928 C. HAMMON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 1926 to March 1, 1928.  
that I last saw her alive on March 1, 1928.

and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH\* was as follows:

Uremia  
Chronic nephritis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY Uremia  
(Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted  
if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. C. Cohen, M. D.

3/1, 1928 (Address) 2238 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Hebrew Burial Home

DATE OF BURIAL

3/2/28

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. 2nd St.



# HEALTH DEPARTMENT—CITY OF BALTIMORE

31181

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *24-35* Ward *Ward*)

### 2-FULL NAME

(a) RESIDENCE NO. *1456 Cedar St.*

(Usual place of abode)

St. *Ward*

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Single*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(duration) .....yrs. ....mos. ....ds.

(Signed) M. D.

(Coroner)

, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. ....mos. ....ds. In the State .....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death:

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

15 Filed 1928

HAROLD JONES, M. D.

Registrar

*Parkwood Cem. Meth. 3 1928*  
*Wm. E. Black 927 N. Broadway*

31182

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 E 31182

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 W North ST. 15-21 WARD)

2-FULL NAME Dr. Rose C. Metzger

(a) RESIDENCE No. 1903 W North

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 28 yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

M W

Married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Laisy Hine Metzger

DATE OF BIRTH (month, day, and year)

April 24/1879

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

48 10 5

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Medical 402

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Md.

10 NAME OF FATHER

Jacob Metzger

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Ellen Brooks

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

14

Informant  
(Address)

Laisy H. Metzger

R 2-1928

HARRISON JONES, M. D.

Md.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1928

17

I HEREBY CERTIFY That I attended deceased from

December 1927 to Feb 29 1928

that I last saw him alive on Feb 25 1928

and that death occurred, on the date stated above, at 8.9. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of kidney, with  
metastases.

(duration) yrs. 4 1/2 mos. ds.

CONTRIBUTORY  
(Secondary)

Cachexia - Inanition

(duration) yrs. 1 mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of Jan. 1928

Was there an autopsy? No

What test confirmed diagnosis? Microscopic-tissue

(Signed) Carroll Lockard, M. D.

WAVE 1928 (Address) 4 L. Preston St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

David Redgben

20 UNDERTAKER

W M Routen

DATE OF BURIAL

March 1928

ADDRESS

225 W North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31183

## CERTIFICATE OF DEATH.

100-001  
E 31183

## 1-PLACE OF DEATH

TY OF BALTIMORE: (No. *837 Cloney* ST. *18-76* WARD)2-FULL NAME *Lara Elvin*(a) RESIDENCE NO. *837 Cloney* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *Cal* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *April 14, 1908*AGE *20* Years Months *10* Days *17* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work, *Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Balt.* (State or country) *md.*10 NAME OF FATHER *William D. Hall*11 BIRTHPLACE OF FATHER (city or town) *md.* (State or country)12 MAIDEN NAME OF MOTHER *Barnie Wilson*13 BIRTHPLACE OF MOTHER (city or town) *md.* (State or country)14 Informant *Barnie Wilson* (Address) *837 Cloney St.*15 Filed *1926* *H. J. Jones, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-1-1928*17 I HEREBY CERTIFY, That I attended deceased from *6-4-1928*, to *3-1-1928*, that I last saw her alive on *2-28-1928*, and that death occurred, on the date stated above, at *1:50 a.m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Ulcerative Colitis**Terminal Bronchitis*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical*(Signed) *R. J. Jones, M. D.*3/1, 1928 (Address) *837 Cloney St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*mt Auburn Cemetery*

20 UNDERTAKER

*Mrs. Kate R. Williams*

DATE OF BURIAL

*Mar 5, 1928*ADDRESS *322**J. Schuchert*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31184

1-PLACE OF DEATH

City of BALTIMORE: (No.

1034 Vine St

St. 18-76 Ward)

2-FULL NAME

Wayman Dent

(a) RESIDENCE NO.

1034 Vine St

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Gold

Single

6 If married, widowed, or divorced

HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

Unknown

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

About 41

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto

(State or country)

10 NAME OF FATHER

Maudus Dent

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Teresa Blair

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

James M. Dent  
200 Rock St

15

Filed

1928

James M. Dent

Registrar

REGISTERED NO. 31184

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONERS CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows

Broncho-Pneumonia

(duration) 1 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 7 mos. 7 ds.

(Signed)

Thos. B. Norton

M. D.

Feb 29-1928 (Address)

Curtis Bay

\*State the Disease Causing Death or in Deaths from Violent Causes, state (1) Means and Nature of Injury, And (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Laurel Cemetery

Mar. 3 1928

20 UNDERTAKER

ADDRESS

Mrs. Kate R. Williams

Schroeder St





E 31186

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31186

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 S. Robinson

ST., 172 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy E. Jones

(a) RESIDENCE NO. 4 S. Robinson

(Usual place of abode)

ST., 1 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white Chief

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct. 19, 1926

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

1 4 10

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work...

Chief

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
md.

10 NAME OF FATHER Farley Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

North Carolina

12 MAIDEN NAME OF MOTHER Vera Harrison

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore  
md.

14

Informant

Farley Jones

(Address)

4 S. Robinson St.

15

AR 2 - 1928

HARRISON JONES, M.  
J. A. Harrison

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 27, 1928, to March 1, 1928.

that I last saw her alive on March 1, 1928.

and that death occurred, on the date stated above, at 4 P. M. m.

The CAUSE OF DEATH\* was as follows:

Sepsis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) Allen Beatham M. D.

3-2, 1928 (Address) 3139 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

Mar 2 - 1928

20 UNDERTAKER

Lilly &amp; Zeller Inc.

ADDRESS

403 S. West St.

E 31187

HEALTH DEPARTMENT-CITY OF BALTIMORE

E 31187

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 902 S. Ellwood Ave. 1-1 Ward)

2-FULL NAME Catharine Ann Over

(a) RESIDENCE NO. 902 S. Ellwood Ave. 1 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S. if of foreign birth 62 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Joseph A. Over

DATE OF BIRTH (month, day, and year) Nov. 2nd 1864

7 AGE 63 Years Months 3 Days 27 IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 37

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Quebec Canada (State or country)

10 NAME OF FATHER Wm O. Brien

11 BIRTHPLACE OF FATHER (City or town) England (State or country)

12 MAIDEN NAME OF MOTHER Ellen Burke

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Sarah Lauretta O'Hara (Address) 902 S. Ellwood Ave

15 Filed 2-19-28 C. HAMPTON JONES, Jr. H. D. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 19 28

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 19 28, to Mar 1, 19 28

that I last saw her alive on March 1, 19 28

and that death occurred, on the date stated above, at 6:38 p. m.

The CAUSE OF DEATH\* was as follows:

Labar Pneumonia

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

CONTRIBUTORY Chronic Myocarditis (Secondary)

(duration) Gradual yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? no Date of \_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Harper B. Titlow M. D.

3/2, 19 28 (Address) 315 S. Highland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cemetery

20 UNDERTAKER Lilly & Guilmer Inc.

Date of Burial

Feb 5 19 28

ADDRESS

403 S. W. [illegible]

E 31188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001  
E 31188

1-PLACE OF DEATH

City of BALTIMORE: (No. 802 W. Pratt

St. 18-29 Ward

2-FULL NAME Elizabeth Brown

(a) RESIDENCE NO. 802 W. Pratt

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Brown

DATE OF BIRTH (month, day, and year)

June 9, 1868

AGE

Years

59

Months

9

Days

21

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant Margaret A. Welsh

(Address) 802 W. Pratt St.

15 Filed 1928

HARRISON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 1

193 8

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed)

Angela Zeller M. D. (Coroner)

3/1, 1928 (Address) 2732 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death:

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cem. 3/3 1928

20 UNDERTAKER

1136



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31189

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST. *13-59* WARD)2-FULL NAME *Mary Walker*

REGISTERED NO. \_\_\_\_\_

E 31189

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2119 Druid Hill Ave.* ST. \_\_\_\_\_

WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

*34* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Female Colored Married*

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Clearance Walker*DATE OF BIRTH (month, day, and year) *Unknown 1894*

AGE

*34*

Years

Months

Days

If LESS than  
1 day, ... hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*House Wife*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Baltimore  
Maryland*

10 NAME OF FATHER

*Samuel J. Williams*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Baltimore*

12 MAIDEN NAME OF MOTHER

*Mary V. Brown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balto  
Md.*14 Informant  
(Address)*Wm. R. Williams  
674 G. St.*

15 Filed

*C. H. JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 29 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Feb 3*, 1928, to *Feb 29*, 1928,that I last saw her alive on *Feb 29*, 1928,  
and that death occurred, on the date stated above, at *8:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Intestinal Obstruction, Peritonitis,  
Bronchopneumonia (rt)*

(duration)

yrs.

mos.

*31* ds.CONTRIBUTORY *Intestinal hernia*  
(Secondary)

(duration)

yrs.

mos.

*5* mos.

18 Where was disease contracted

if not at place of death?

*2119 Druid Hill Ave.*Did an operation precede death? *No*

Date of \_\_\_\_\_

Was there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy*

(Signed)

*Sherman S. Garrett M. D.*

2-29, 1928 (Address)

*University Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*New Cathedral Cmt.**Mar. 3, 1928*

20 UNDERTAKER

ADDRESS

*Mrs. R. G. Elliott**1725  
Ashland Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31190

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31190

## PLACE OF DEATH

CITY OF BALTIMORE: (No. *1307 West North Ave.* ST. *14-20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME *Meriam B. Ploughman (Plowman)*(a) RESIDENCE No. *1323 W. North Ave.* ST. *14-20* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*

6 If married, widowed, or divorced

HUSBAND or WIFE of *William Ploughman*7 DATE OF BIRTH (month, day, and year) *August 15, 1890*AGE *38* Years *6* Months *14* Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housekeeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) *Pennsylvania* (State or country)9 NAME OF FATHER *Lewis Mourraye*10 BIRTHPLACE OF FATHER (city or town) *Penn.* (State or country)11 MAIDEN NAME OF MOTHER *Mary Mourraye*12 BIRTHPLACE OF MOTHER (city or town) *Penn.* (State or country)

13

Informant *William O. Plowman* (Address) *1307 W. North Ave.*

14

Filed *1928* 19 *2*Registrar *K. L. H.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 29, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *February 27, 1928*, to *February 29, 1928*, that I last saw her alive on *February 29, 1928*, and that death occurred, on the date stated above, at *8:20 P.* m.

The CAUSE OF DEATH\* was as follows:

*Angina Pectoris*  
*Chronic Myocarditis*  
*Fatty infiltration and degeneration of heart.*CONTRIBUTORY (Secondary) *Cardi-vascular failure*(duration) yrs. mos. ds. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Frank R. McPaul* M. D.

, 19

(Address) *1323 W. North Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Parkwood Cemetery*DATE OF BURIAL *Mar. 3, 1928*20 UNDERTAKER *E. Le Roy Stiffles*ADDRESS *125 E. North Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31191

E 31191

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Provident Hospital* S. *11-24* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Ward

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Female**col.**Widowed*

## 6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Warren Gault*

## DATE OF BIRTH (month, day, and year)

*1893*

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..*35*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Housewife*  
*at home*

## 9 BIRTHPLACE (city or town)

(State or country)

*Md.*

## 10 NAME OF FATHER

*Nace Fletcher*

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Md.*

## 12 MAIDEN NAME OF MOTHER

*Sarah Kelem*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Md.*

## 14

Informant  
(Address)*W. V. Sewell*  
*Doris Md.*

## 15 Filed

*1928**C. HANCOCK JONES, M.D.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-1-1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*2-10-1928*, to *3-1-1928*,that I last saw her alive on *2-29-1928*,and that death occurred, on the date stated above, at *4 a. m.*

The CAUSE OF DEATH was as follows:

*Lachry ulcer*  
*Hemorrhage*(duration) ..... yrs. .... mos. *19* ds.

## CONTRIBUTORY

(Secondary)

(duration) ..... yrs. .... mos. .... ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *2-15-28*Was there an autopsy? *no*What test confirmed diagnosis? *clinical*

(Signed)

*3/1/1928* (Address) *Sosw Barato*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Belmont Point Chapel**Mar. 2 1928*

## 20 UNDERTAKER

ADDRESS

*W. V. Sewell*  
*Doris Md.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31192

## CERTIFICATE OF DEATH.

X 131 E 31192

1-PLACE OF DEATH *Franklin Square Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *Calhoun + Bayette* ST. *14-16* WARD)2-FULL NAME *Louis J. Seisman*(a) RESIDENCE NO. *Clifton Ave + Remond Drive* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *10* mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male**white**single*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *April 22, 1927*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*10**7*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*infant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Baltimore  
md.*

10 NAME OF FATHER

*Louis J. Seisman*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*New York, City -*

12 MAIDEN NAME OF MOTHER

*Gertrude Heacock*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore, md.*

14

Informant

(Address)

*Sister**1927*

Filed

*E. HAMPTON JONES, M.D.*

For

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 1 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Dec. 15, 1927, to Mar 1, 1928.*that I last saw him alive on *Feb 24, 1928.*and that death occurred, on the date stated above, at *9:05 A. m.*

The CAUSE OF DEATH\* was as follows:

*Pyelitis, Stitias medica-*(duration) yrs. *3* mos. ds.CONTRIBUTORY  
(Secondary)*Meningitis (pneumococcus)*(duration) yrs. mos. *23* ds.

18 Where was disease contracted

if not at place of death? *home*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Spinal puncture*(Signed) *Elizabeth Sherman*, M. D.19 (Address) *Franklin Square Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*New Catholic Church  
Seach Syfer 4100 North  
Ave*



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31193

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

Length of residence in city or town where death occurred

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* Color or Race *white* Single, Married, Widowed, or Divorced *Widowed*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years *65* Months *1* Days *21* IF LESS than 1 day.....hrs. or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filed

Per

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained and that said deceased came to death

topsy or inquiry.) on the day stated above. The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed) *John P. Burton* M. D.

(Address) *Curtis Bay*

\*State the Disease Causing Death, or if from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31194

## CERTIFICATE OF DEATH

74-001  
E 31194  
REGISTERED NO.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 2435 Calverton Heights 16-68 Ward)

2-FULL NAME Morris C. Brotherton

(a) RESIDENCE NO. 2435 Calverton Heights Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 9 mos. 2 da. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? 82 yrs. 9 mos. 2 da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Mattingly

DATE OF BIRTH (month, day, and year) May 28, 1845

7 AGE Years 82 Months 9 Days 2 IF LESS than 1 day 3 hrs. or 3 min..

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired B. O. Conductor  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER John P. Brotherton

11 BIRTHPLACE OF FATHER (City or town) Sienna  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Sienna  
(State or country)

14 Informant Mrs. Lydia V. Stearns  
(Address) 2435 Calverton Heights Ave.

15 Filed 1928 HAMPSON JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1928

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1927, to March 1, 1928, that I last saw him alive on March 1, 1928, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows:  
Oblique Coronary Artery

CONTRIBUTORY (Secondary) Arteriosclerosis  
hypertension

18 Where was disease contracted  
If not at place of death? ✓

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. H. Harrison, M. D.  
, 19 28 (Address) 1900 Calverton Heights Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

Date of Burial March 5, 1928

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Calverton Heights Ave.

31195

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 H Behnd Ave -10 ST., WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

(Married, widowed, or divorced)  
HUSBAND of  
or WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

Address

M. D.

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 31196

## HEALTH DEPARTMENT - CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1078. 2nd St. 25-75 Ward)

## 2-FULL NAME

Donald J. Hoffman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1078 2nd Brooklyn St. 25-75 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Mar 1 1928

## 7 AGE

Years

Months

Days

IF LESS than 1 day 1 hr. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Balto. Md

## 10 NAME OF FATHER

Edgar L. Hoffman

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Mildred Chromatic

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

## 14

Informant (Address)

Edgar L. Hoffman  
1078. Second St Brooklyn

## 15

Filed

2 - 1928

16

17

18

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

Mar 1 - 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

3/1 - 1928, to 3/1/28, 19that I last saw him alive on 3/1/28, 19and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH\* was as follows

Ch. M. M. & family  
frustration for 6 months

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

M. D.

\*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Green Hill CemeteryMar 2 1928

## 20 UNDERTAKER

John F. Denny

ADDRESS

115 Light St



31197

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31197

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2538 Druid Hill Ave ST. 19-59 WARD)

### 2-FULL NAME

Frank Palm

Residence in Baltimore: No. 2538 Druid Hill Ave St.; 1 yrs., 0 mos., 0 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

DATE OF BIRTH,

Nov 7, 1864  
(Month) (Day) (Year)

AGE,

64

If LESS than 1 day,

....hrs. or....min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

Barber

BIRTHPLACE, (State or Country),

Pittsburg Pa

10-NAME OF FATHER,

Henry Palm

11-BIRTHPLACE OF FATHER

(State or Country),

Penn

12-MAIDEN NAME OF MOTHER

Jane Simpson

13-BIRTHPLACE OF MOTHER

(State or Country),

Penn

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Annie Palm

(Address).....

2538 Druid Hill Ave

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb, 29, 1928  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7, 1927, to Feb 29, 1928,

that I saw him alive on Feb 28, 1928,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Valvular Heart Disease

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....J. E. Daugherty M. D.

Mar 1, 1928 (Address) 160 E. Pratt St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

St. Andrew's

March 2, 1928

20-UNDERTAKER

ADDRESS

Sam Carter

916

Filed.....C. H. HAMPSON JONES, M. D. Registrar

1928

31198

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31198

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Springhill Terrace & 91a York Road)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Williams(a) RESIDENCE NO. 3242 Barclay St

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	married

If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofEllen Williams

DATE OF BIRTH (month, day, and year)

Dec 11/1857

AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	70	2	17	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) King & Queen Co

(State or country)

Va.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va14 Informant Ellen Williams

(Address)

3242 Barclay St

15 Filed

19 C. HAMPTON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 28/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry find that said deceased came to his death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

2/29/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Land3/3 1928

20 UNDERTAKER

ADDRESS

R. L. Pahan 829 Benav

31199

# HEALTH DEPARTMENT—CITY OF BALTIMORE

31199

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *3008 E Baltimore*  
CITY OF BALTIMORE: (No. *6-11* ST., *6-11* WARD)

2-FULL NAME *Mary Clara Hoffman*

(a) RESIDENCE NO. *3008 E Balto*  
(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Sept 29, 1860*  
AGE Years Months Days If LESS than 1 day, hrs. or min.

*67 5 0*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Hager*  
(State or country) *Pa.*

10 NAME OF FATHER *John Hoffman*

11 BIRTHPLACE OF FATHER (city or town) *Pa*  
(State or country)

12 MAIDEN NAME OF MOTHER *Anna Adams*

13 BIRTHPLACE OF MOTHER (city or town) *Pa*  
(State or country)

14 Informant (Address) *Robert Hoffman*

15 *1928* C. HAMPSON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 29 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 22 1928* to *Feb 29 1928* that I last saw her alive on *Feb 29 1928* and that death occurred, on the date stated above, at *322 A. m.*

The CAUSE OF DEATH\* was as follows: *Acute Bronchitis - la grippe*

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) *Hypostatic pneumonia* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clin. data*  
(Signed) *Leopold Hager* M. D.  
, 19 (Address) *3034 E Baltimore*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR DE- DATE OF BURIAL

*St. Peter's, Ind.* *3/3 1928*  
20 UNDERTAKER *J. J. Moran* ADDRESS *3008 E Baltimore*

31200

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

124 E 31200

-PLACE OF DEATH

Y OF BALTIMORE: (No.

-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

57 yrs. 6 mos. 17 ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

6 married, widowed, or divorced HUSBAND of (or) WIFE of

*Anna C.*

DATE OF BIRTH (month, day, and year)

*June 11, 1875*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*52 yrs.**6**17*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Tailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Wm. A. Krager*

BIRTHPLACE (city or town) (State or country)

*Balto.*

10 NAME OF FATHER

*Joseph Roeselein*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

Informant (Address)

*Joseph Roeselein (son) 7 N. Duncan St.*

File

*1928 C. HAMPTON JONES*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-28-1928*

17

I HEREBY CERTIFY, That I attended deceased from *2-26*, 19*28*, to *2-28*, 19*28*.that I last saw him alive on *2-28*, 19*28*.and that death occurred, on the date stated above, at *1-28* m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia**over*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

*Uremia - No report*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Culture*

(Signed)

*John G. Astor* M. D.

19

(Address)

*Sever Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

*Holy Redeemer**John G. Connelly*

DATE OF BURIAL

*3/3-1928*

ADDRESS

*Cox*



HEALTH DEPARTMENT—CITY OF BALTIMORE

31201

E 31201

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. *90*)

St., *4-35* Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Mr. Paul*

(a) RESIDENCE NO.

*1315 Cooswick*

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male*

*White*

*Married*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*December 8, 1867*

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

*60*

*2*

*21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Bricklayer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Austria*

10 NAME OF FATHER

*Mr. Paul*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Austria*

12 MAIDEN NAME OF MOTHER

*Margaret Thompson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Austria*

14

Informant (Address)

*Hospital Records*

15 Filed

*C. HAMPSON JONES, M. D.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 29, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 23, 1928 to Feb. 29, 1928*

that I last saw him alive on

*Feb. 29, 1928*

and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis & decomposition*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

*Acute dilatation of heart*

(duration) yrs. mos. ds.

*3 months*

18 Where was disease contracted

If not at place of death?

*Home*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*Medical*

*John S. Connelley, M. D.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Holy Cross. A. A. Co.*

*3/5/ 1928*

20 UNDERTAKER

*John S. Connelley*

ADDRESS

*Connelley*

1928

31202

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31202

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1805 Guilford Ave. ST. 12-19 WARD)

## 2. FULL NAME Harry N. Rayler

(a) RESIDENCE NO. 1805 Guilford Ave. ST. 12-19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE Male White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Willie D. Gladfelter Rayler

DATE OF BIRTH (month, day, and year) June 9-1880

AGE

Years 47

Months 8

Days 22

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 73

(b) General nature of industry, business, or establishment in which employed (or employer) Penna. R.R.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Howard B. Rayler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary E. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14

Informant (Address) Mrs. Willie D. Gladfelter Rayler 1805 Guilford Ave.

15

REG.

1920

G. H. HAMMON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1928

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1927, to Mar 28, 1928, that I last saw him live on Feb 25, 1928, and that death occurred, on the date stated above, at 12:15 A. M.

The CAUSE OF DEATH\* was as follows:

Dilatation of Heart

CONTRIBUTORY (Secondary) Rheumatic Fever

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart section (Signed) W. H. Pearce, M. D.

(Address) 2105 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Grundy Ridge March 5 1928  
Lorain H. Burgee 3631 Falls Rd

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31203

31203

## CERTIFICATE OF DEATH.

PLACE OF DEATH

Y OF BALTIMORE: (No.

FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

48 yrs. 8 mos. 18 ds.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

1928

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-1-1928

17

I HEREBY CERTIFY, That I attended deceased from

2-9-28, 19, to 3-1-1928,

that I last saw him alive on 3-1-1928,

and that death occurred, on the date stated above, at 11:00 P. M.

The CAUSE OF DEATH was as follows:

Myocarditis, Chronic Coronary Thrombosis

CONTRIBUTORY (Secondary)

18 Where was disease contracted (If not at place of death?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Seroghty, M. D.

, 19 (Address) Union Memorial Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

31204

HEALTH DEPARTMENT—CITY OF BALTIMORE E 31204

CERTIFICATE OF DEATH.

75-001

1-PLACE OF DEATH *Church Home & Infirmary*  
 CITY OF BALTIMORE: (No. *Broadway & Fairmount* WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Elmore B. Scarff*

(a) RESIDENCE NO. *Ruxton Md.* ST. \_\_\_\_\_ WARD *Ruxton Md.*  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred 0 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? 78 yrs. 4 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*  
 If married, widowed, or divorced HUSBAND of (or) WIFE of *Dr. John S. Scarff*  
 DATE OF BIRTH (month, day, and year) *Oct 23/1849*  
 AGE Years *78* Months *4* Days *9* If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. *none*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *none*  
 (c) Name of employer *none*

BIRTHPLACE (city or town) *Richmond Va.*  
 (State or country)

PARENTS

10 NAME OF FATHER *John S. Graner*  
 11 BIRTHPLACE OF FATHER (city or town) *Richmond Va.*  
 (State or country)  
 12 MAIDEN NAME OF MOTHER *Ethelene Brown*  
 13 BIRTHPLACE OF MOTHER (city or town) *Balto.*  
 (State or country)

14 Informant *Mr. John S. Sanford - (em)*  
 (Address) *Ruxton - Md.*

15 *1928* *C. HAMPTON JONES, M. D.*  
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 2* 19 *28*

17 I HEREBY CERTIFY, That I attended deceased from *Dec 26*, 19 *27*, to *March 2*, 19 *28*, that I last saw her alive on *March 2*, 19 *28*, and that death occurred, on the date stated above, at *1 P. M.*  
 The CAUSE OF DEATH\* was as follows:  
*Broncho Pneumonia*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *14* ds.  
 CONTRIBUTORY *Hemiplegia*  
 (Secondary) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *76* ds.

18 Where was disease contracted *Church Home & Infirmary*  
 if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *no*

What test confirmed diagnosis? *Physical Examination*  
 (Signed) *J. Frank Hewitt*, M. D.

*4/2, 1928* (Address) *Church Home & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL *Richmond Va. Mar 3/ 1928*

UNDERTAKER *Stewart & Sons Balto.*



31205

# HEALTH DEPARTMENT—CITY OF BALTIMORE

84 E 31205

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. *Calvin Court Apt 17-50* St. *17-50* Ward)

Registered No. ....

### 2-FULL NAME

(a) Residence No. *Apt 3 E*

(Usual place of abode)

St. .... Ward .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

Now long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

### PERSONAL AND STATISTICAL PARTICULARS.

SEX.

*Male*

4-COLOR OR RACE,

*White*

5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

If married, widowed, or divorced, HUSBAND (Name) WIFE (Name)

*Blanche Hope Gile*

DATE OF BIRTH (month, day and year)

*March 11 1875*

AGE,

*52 yrs. 11 mos. 19 ds.*

If LESS than 1 day,

...hrs. or...min.?

### OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

*Lawyer*

(b) General nature of industry, business, or establishment in which employed (or employer).

*Self*

(c) Name of employer.

BIRTHPLACE (city or town) (State or Country),

*Baltimore Maryland*

10-NAME OF FATHER,

*N. Rufus Gile*

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

*Baltimore Co. Md.*

12-MAIDEN NAME OF MOTHER,

*Agnes Gile*

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

*Baltimore Co. Md.*

14-

(Informant),

*Mrs. Blanche G. Gile*

(Address),

*Calvin Court Apt 3 E Calvert St.*

15-

Filed,

*1926*

*C. HAMPSON JONES, M. D.*

Reg.

Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *March 1 1928*

17-I HEREBY CERTIFY, That I attended deceased from *Feb 14 1928* to *March 1 1928*

that I last saw him alive on *Feb 29 1928*

and that death occurred, on the date stated above, at *4 a.m.*

The CAUSE OF DEATH\* was as follows:

*Acute Dilation Heart*

CONTRIBUTORY (Secondary)

*Cerebral Aneurysm*

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of.

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Wm. H. Thompson, M. D.*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

*Greenmount Cemetery March 13 1928*  
*Hughes & Ford 411 Broadway*

31206

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31206

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1611 E. Preston* St. *7-13* Ward)Registered No. *129*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *David Bernard Schuchts*(a) Residence No. *1611 E. Preston* St. *7-13* Ward. (If non resident give city or town and State)Length of residence in city or town where death occurred *60* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the words) *Married*If married, widowed, or divorced HUSBAND of (or) WIFE *Mary D. Schuchts*DATE OF BIRTH (month, day and year) *Dec 12-1843*AGE, *84* yrs. *2* mos. *18* ds. If LESS than 1 day, hrs. or min.?

## OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Retired millwright*(b) General nature of industry, business, or establishment in which employed (or employer) *Retired*(c) Name of employer *Retired*BIRTHPLACE (city or town) (State or Country), *Baltimore Md.*10-NAME OF FATHER, *James Schuchts*11-BIRTHPLACE OF FATHER (city or town) (State or Country), *Md.*12-MAIDEN NAME OF MOTHER, *Ellen Townsend*13-BIRTHPLACE OF MOTHER (city or town) (State or Country), *Md.*14- (Informant) *Mrs. Gertrude Lewis* (Address) *1611 E. Preston St.*

15- C. HAMPTON JONES, M. D. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *March 1st 1928*17- I HEREBY CERTIFY, That I attended deceased from *Jan 25* to *Feb 1*that I last saw him alive on *Feb 29* 19 *28*and that death occurred, on the date stated above, at *9:15 A* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*CONTRIBUTORY (Secondary) *Preliminary Cedema*(Duration) yrs. mos. ds. *6* yrs. *2* mos. *2* ds.18-Where was disease contracted *✓* If not at place of death?Did an operation precede death? *✓* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *Urinalysis*(Signed) *Ralph E. Brown* M. D., 19 (Address) *26 E. Preston St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, *Baltimore Cemetery* DATE OF BURIAL, *Mar 3 1928*20-UNDERTAKER, *Hughes & Mel* ADDRESS *11 Broadway*

31207

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31207

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *2009 N. Lafayette*)

2-FULL NAME

Residence in Baltimore: No. *2009 N. Lafayette*Registered No. C. *90*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX,

*female*

4-COLOR OR RACE,

*White*5-Single, Married, *Single*, Widowed, or Divorced, (Write the word.)

DATE OF BIRTH,

*1**?**1866*

(Month)

(Day)

(Year)

AGE,

*62*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*none*

9-BIRTHPLACE, (State or Country).

*Baltimore*

10-NAME OF FATHER,

*Henry Franklin*

11-BIRTHPLACE OF FATHER, (State or Country).

*England*

12-MAIDEN NAME OF MOTHER,

*Lelina Moses*

13-BIRTHPLACE OF MOTHER, (State or Country).

*England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Fred W. Franklin*

(Address)

*1723 N. Lafayette*

15-

Filed

*C. HAMPTON JONES, M. D.*

Registrar.

1928

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Mar 1*

(Month)

(Day)

*1928*  
(Year)

17-

I HEREBY CERTIFY

That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or Inquiry.)thereon and from the evidence obtained by said *Inquiry* (Inquest, au-

topsy and find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Mitral Stenosis*

CONTRIBUTORY (Secondary)

*Mar 1* (Duration) yrs. mos. ds.*2/20* (Duration) yrs. mos. ds.*1436 Bway* (Address)

HEALTH DEPARTMENT—CITY OF BALTIMORE

31208

90 E 31208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2226 Boston

St. 1-3 Ward

2-FULL NAME Stanock Lubuch

(a) RESIDENCE NO. 2712 Elliott

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs.

mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 18 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)  
Male White Married

If married, widowed, or divorced  
HUSBAND of Jennie Lubuch  
(or) WIFE of

DATE OF BIRTH (month, day, and year)  
May 28, 1881

AGE Years Months Days IF LESS than  
46 9 1 1 day.....hrs.  
or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town)

(State or country) Jugo-Slovakia

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Not Known

PARENTS

14 Informant Mrs. Stella Boydanovich (Neice)  
(Address) 2712 Elliott St.

15 1928 C. HAMMOND JONES, M. D.  
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held at  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Stenosis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.  
Exhaustion  
Signed J. C. Blades, M. D.  
(Address) 143 N. Barry

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mount Carmel Cemetery

Mar. 3. 1928

20 UNDERTAKER

Henry Sander & Sons Inc 1710 Fleet St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31209

## CERTIFICATE OF DEATH.

E 31209

PLACE OF DEATH

OF BALTIMORE: (No. 2428 E. Baltimore

ST. 6-10 WARD)

-FULL NAME James Alfred Corron

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO. 2428 E. Baltimore

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

18

yrs.

mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

married, widowed, or divorced

HUSBAND of

(or) WIFE of Anna Bradley Corron

DATE OF BIRTH (month, day, and year) April 18, 1882

AGE

Years

45

Months

10

Days

13

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunchroom Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Virginia

10 NAME OF FATHER James Corron

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER Jenny Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

Informant  
(Address)(Mrs. Lena Dickerson, (Sister)  
452 10th St. S.W. Washington D.C.

Filed

1928

19

HAMPSON, JAMES H. B.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 19 28

17

I HEREBY CERTIFY, That I attended deceased from

Jan 15, 1928, to Mar 17, 19 28.

That I last saw him alive on Feb 29, 19 28.

and that death occurred, on the date stated above, at 11.05 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of  
tongue

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed)

Dr. H. Pearce, M. D.

, 19

(Address)

2105 4th St. S.W.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Congressional Cemetery Wash. D.C. Mar. 3, 28

20 UNDERTAKER

Henry Sander &amp; Sons Inc

ADDRESS

Baltimore St.  
& Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31210

31210

## CERTIFICATE OF DEATH.

-PLACE OF DEATH

Y OF BALTIMORE: (No. *319 St. Paca* ST. *22-30* WARD)-FULL NAME *Alvinia Morris*(a) RESIDENCE No. *319 St. Paca* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*married, widowed, or divorced  
HUSBAND of  
or) WIFE of *William Morris*DATE OF BIRTH (month, day, and year) *Jan 16-1870*AGE Years *58* Months *1* Days *15* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *St. Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Balto Md*  
(State or country)10 NAME OF FATHER *untown*11 BIRTHPLACE OF FATHER (city or town) *Maryland*  
(State or country)12 MAIDEN NAME OF MOTHER *untown*13 BIRTHPLACE OF MOTHER (city or town) *Maryland*  
(State or country)Informant *Berman W. Morris*(Address) *319 St. Paca*C. HAMPSON JONES, M. D.  
1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-1-1928*17 I HEREBY CERTIFY, That I attended deceased from *Feb 29, 1928* to *March 1, 1928*.  
that I last saw her alive on *Feb 29, 1928*and that death occurred, on the date stated above, at *1154*

The CAUSE OF DEATH\* was as follows:

*Father Degeneration of heart muscles*(duration) yrs. *6* mos. ds.CONTRIBUTORY (Secondary) *none*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *C. A. Beaver*, M. D.1/2 1928 (Address) *3401 Fairview*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *London Park*

DATE OF BURIAL

*3/3 1928*UNDERTAKER *Wm Cook*

ADDRESS

*552 E North*

31211

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31211

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

OF BALTIMORE: (No. *Hopkins Apt. 2* ST. *17-50* WARD)FULL NAME *Ellen N. Lynch*RESIDENCE No. *2736 St Paul*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*Married, widowed, or divorced HUSBAND of (or) WIFE of *Joshua Lynch*DATE OF BIRTH (month, day, and year) *Feb - 18 44*AGE *84*Years *82*Months *11*Days *0*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Balto Md*

(State or country)

10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town) *Balto Md*

(State or country)

12 MAIDEN NAME OF MOTHER *Jane Jones*13 BIRTHPLACE OF MOTHER (city or town) *Balto Md*

(State or country)

Informant *John T. Lynch*

(Address)

Filed *1928*

19

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 2, 19 28*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 1926*, 19 to *March 1*, 19 *28*, that I last saw her alive on *March 1*, 19 *28*, and that death occurred, on the date stated above, at *530 A* m.

The CAUSE OF DEATH\* was as follows:

*Arterio-Sclerosis & myocardial degeneration*(duration) *1* yrs. *8* mos. ds.CONTRIBUTORY (Secondary) *Acute Cardiac Dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no*

Date of

Was there an autopsy? *no*What test confirmed diagnosis? *This*(Signed) *Stanley M. M. D.*

, 19

(Address) *1609 Linden Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Cemetery**3/3-1928*

20 UNDERTAKER

ADDRESS

*William Cook**502 E North St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31212

## CERTIFICATE OF DEATH

96E 31212

PLACE OF DEATH

OF BALTIMORE, NO.

FULL NAME

RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

23 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

married, widowed, or divorced

HUSBAND of  
or) WIFE of

Mary Frances Boyden

DATE OF BIRTH (month, day, and year)

July - 1 1856

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

71

7

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Inventor

(b) General nature of industry, business, or establishment in which employed (or employer)

Self

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Pennsylvania

10 NAME OF FATHER

William Boyden

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Eng Land

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

Informant

(Address)

Mrs G. R. Gable  
6610 N. 11th St Phila

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 - 1928

17

I HEREBY CERTIFY, That I attended deceased from

Dec - 3, 1927, to Mar - 1, 1928

that I last saw him alive on Mar - 1, 1928

and that death occurred, on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Edema  
Mitral Regurgitation, Left  
Hemiplegia due to Cerebral Hemorrhage

CONTRIBUTORY (Secondary) (duration) 4 yrs. 4 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pulmonary Organ

(Signed) M. Abramson M. D.

3/2, 1928 (Address) 522 Klammer Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

3/3 - 1928

ADDRESS

Druid Ridge Cemetery

William Cook

502 E. 16th St



HEALTH DEPARTMENT—CITY OF BALTIMORE

31213

CERTIFICATE OF DEATH

E 31213

1-PLACE OF DEATH

City of BALTIMORE: (No. 1403 Patapoco

23-33  
St. Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Martin Braun

(a) RESIDENCE NO. 1403 Patapoco

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred about 60 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? about 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

Male White Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

Anna Braun

DATE OF BIRTH (month, day, and year)

June 9, 1864

AGE

Years

Months

Days

7 LESS than 1 day hrs. or min.

63 8 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Retired Carpenter

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

John Braun

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Happel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Mrs. Anna Braun 1403 Patapoco St.

15

1928

19

MARGARET JONES

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 28 1928

17 I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1928, to Feb 28, 1928.

that I last saw him alive on Feb 27, 1928.

and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Carcinoma of Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Schusset, M.D.

Address 1337 S. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Cross A.C.C.

Mar 3, 1928

20 UNDERTAKER

ADDRESS

Margaret S. Flynn 1422 High St.

1214

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31214

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE No.

(Usual place of abode)

th of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant

(Address)

1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

2/29, 1928, to

8/2, 1928

that I last saw him live on

8/2, 1928

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

(duration)

yrs.

mos.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31215

## CERTIFICATE OF DEATH.

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. U.S. Marine Hospital

ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Helge O. Olafsen

a) RESIDENCE No. Aliceanna &amp; Bethel St.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

28

How long in U. S., if of foreign birth?

12

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

 married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

DATE OF BIRTH (month, day, and year) June 4, 1898

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29	8	26	27

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) A.B. Seaman

(c) Name of employer S.S. Maltran

BIRTHPLACE (city or town)  
(State or country)

Norway

10 NAME OF FATHER Olaf Olafsen

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Norway

12 MAIDEN NAME OF MOTHER Pedra Hendrickson

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Norway14 Informant Records U.S. Marine Hospital,  
(Address) Baltimore, Md.

15 Filed 1928 19 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 19 28

17

I HEREBY CERTIFY, That I attended deceased from February 26, 19 28, to March 1, 19 28,

that I last saw him alive on March 1, 19 28,

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH\* was as follows:

Nephritis, chronic, interstitial

(duration) Unknown mos. ds.

CONTRIBUTORY Tonsillitis, chronic  
(Secondary)

(duration) several yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) A. H. Hendrickson, M. D.

19 (Address) U.S. Marine Hospital, Balto.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Mary's Hospital Mar 3, 19 28

20 UNDERTAKER

ADDRESS

E. L. Roy-Stuffer 125 E. North

1216

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31216

PLACE OF DEATH

OF BALTIMORE: (No. 5314, Wendley Rd. 5-71 ST. WARD)

FULL NAME William H. Driver

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

a) RESIDENCE NO. 5314 Wendley Rd. ST. WARD  
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
 (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

Daisy L. Krouch

DATE OF BIRTH (month, day, and year) March 2, 1895

AGE 33. Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

B & O RR

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER Chas. F. Driver

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER Catherine Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

Informant (Address)

Mr. Daisy L. Driver 5314 Wendley Rd.

1926 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1928

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1927 to Mar 2, 1928

that I last saw him alive on Mar 1, 1928

and that death occurred, on the date stated above, at 5:15 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. x mos. x ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination (Signed) J. Edw. Saylor, M. D.

4/3, 1928 (Address) 1355 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Home

March 5, 1928

20 UNDERTAKER

ADDRESS

John J. Gowan & Co., 901 Hallway



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31217

E 31217

## CERTIFICATE OF DEATH.

PLACE OF DEATH

Y OF BALTIMORE (No. 1103 David Hill Ave.)

FULL NAME Joseph Benjamin

(a) RESIDENCE NO. 1103 David Hill Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

Single, Married, Widowed, or Divorced (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1890

AGE

Years

Months

Days

If LESS than 1 day. hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1928, to Feb. 29, 1928.

that I last saw him alive on Feb. 29, 1928.

and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE

DATE OF BURIAL

UNDERTAKER

MAR 3 - 1928 C. HAMPSON JONES, M. D.

HEALTH DEPARTMENT—CITY OF BALTIMORE

31218

CERTIFICATE OF DEATH

129E 31218

1-PLACE OF DEATH

City of BALTIMORE: (No. 231 Ben Hoop St. 11-24 Ward)

2-FULL NAME

Emma Zamostney

(a) RESIDENCE NO.

Salley, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female white Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Sept 16th 1894

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

33 5 14

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Home

9 BIRTHPLACE (city or town)

(State or country)

Md.

10 NAME OF FATHER

Geo. Mellink

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Anna Malik

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Bohemia

14

Informant (Address)

Hospital Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

3-1-28

17

I HEREBY CERTIFY, That I attended deceased from

2/23, 1928, to 3-1, 1928

that I last saw her alive on 3-1-28, 19

and that death occurred, on the date stated above, at 10:30 P.

The CAUSE OF DEATH\* was as follows:

Myocarditis  
Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. Thompson, M. D.

. 19 (Address) 1100 E. 11th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Cross C.C. Co.

Mar 7 1928

20 UNDERTAKER

ADDRESS

Frank Crockett

1800 E. 11th St.

MAR 3 - 1928

C. HAMPTON JONES

Per Latol

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31219

31219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2032 Ashland Ave St. 7-13 Ward)

2-FULL NAME John Krall

(a) RESIDENCE NO. 2032 Ashland Ave St. 7-13 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

married

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Antonie Krall

DATE OF BIRTH (month, day, and year)

June 16/1870

AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

57

8

14

15

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Bohemia

10 NAME OF FATHER

Charles Krall

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Bohemia

14

Informant  
(Address)

Antonie Krall

2032 Ashland Ave

1928

C. HAMMOND JONES, M. D.

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry

(Inquest, au-

topsy or inquiry.) Had that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

(Address)

508 E. North Ave

3/1/28

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

In the

of death.....yrs., ....mos., ....ds. State.....yrs., ....mos., ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Mar 5 1928

20 UNDERTAKER

ADDRESS

Quaker Burial Home

1906 Ashland Ave

31220

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 31220

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2719 Fenwick Ave ST. 9-44 WARD)

### 2-FULL NAME

Harriett Ann Lamb

### (a) RESIDENCE NO.

Westernport, Md. ST. WARD

(Usual place of abode)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

ys.

2 mos.

13 ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

If married, widowed, or divorced

HUSBAND of (or) WIFE of

John Henry Lamb

DATE OF BIRTH (month, day, and year)

March 11, 1865

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

11

19

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Annapolis  
Md.

10 NAME OF FATHER

Joseph Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Annapolis  
Md.

12 MAIDEN NAME OF MOTHER

Anna Highmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Annapolis  
Md.

14

Informant (Address)

John Henry Lamb -  
Westernport, Md.

15

1928

C. HAMPSON JONES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1928

17

I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1927, to March 1, 1928, that I last saw her alive on March 1, 1928 and that death occurred, on the date stated above, at 5:20 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Arteriosclerosis  
Chr. Myocarditis  
Myocardial Insufficiency

(duration) yrs. 2 mos. 18 ds.

CONTRIBUTORY (Secondary)

Pulmonary oedema  
(duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No - Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical Evidence

(Signed)

Geo. B. Heybert, M. D.

, 19

(Address) 2802 Highland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Anne, Annapolis

March 1, 1928

20 UNDERTAKER

ADDRESS

Geo. M. Smith

81 N. W. 4th



31221

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31221

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

OF BALTIMORE: (No. 1633 N. Carey ST. 15-21 WARD)

FULL NAME Mary Elizabeth Washington

RESIDENCE No. 1633 N. Carey ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) widow

Married, widowed, or divorced HUSBAND or (or) WIFE of Peter Washington

DATE OF BIRTH (month, day, and year)

AGE 85 Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Howard Co. Md. (State or country)

10 NAME OF FATHER Geo. Rauldall

11 BIRTHPLACE OF FATHER (city or town) Howard Co. Md. (State or country)

12 MAIDEN NAME OF MOTHER Anna Brighton

13 BIRTHPLACE OF MOTHER (city or town) Howard Co. Md. (State or country)

Informant Carrie Dorsey (Niece) (Address) 1633 N. Carey St.

1928 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 19 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1928, to Feb. 19, 1928, that I last saw her alive on Feb. 28, 1928, and that death occurred, on the date stated above, at 12:20 P. M. The CAUSE OF DEATH\* was as follows:

Chr. Myocarditis

CONTRIBUTORY (Secondary) Chr. Arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination (Signed) Daniel Brown, M. D.

1928 (Address) 1837 Penn. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mt. Auburn cemetery

DATE OF BURIAL

20 UNDERTAKER

Thomas E. Nelson

ADDRESS

1303 Brewster St



31223

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31223

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

36 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

MAR 3 - 1928

C. HAMPSON JONES

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 14, 1928, to Mar 2, 1928.

that I last saw her alive on

and that death occurred, on the date stated above, at 3.30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis  
(duration) yrs. 3 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Mar 2 1928  
(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 31224

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31224

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1900 W. Lombd. St., 70-28 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Reichenbecker

(a) RESIDENCE NO. 1900 W. Lombard St. Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race Wht 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Louise Butterfield

DATE OF BIRTH (month, day, and year)

Sept 19/1877

AGE Years 50 Months 5 Days 12 IF LESS than 1 day.....hrs. or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Trav. Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Hill Bros. new Directory Co.

(c) Name of employer

Richmond V. Co.

BIRTHPLACE (city or town) Balto.

(State or country)

Md.

10 NAME OF FATHER Wm Reichenbecker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Margt. Rodemier

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ger.

14

Informant (Address)

Ms Lottie Carmack  
1900 W. Lombd. St.

MAR 3 - 1928

C. HAMPTON JONES, Jr.  
St. Louis

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2nd 1928

17

I HEREBY CERTIFY, That I attended deceased from

July 17, 28, Feb 2nd 28,

that I last saw him alive on Feb 14, 28,

and that death occurred, on the date stated above, at 1300 m.

The CAUSE OF DEATH\* was as follows:

Edema of lungs with Nephritis, secondary of some duration

(duration) yrs. mos. ds. 3

CONTRIBUTORY Dropsy

(Secondary)

(duration) yrs. mos. ds. 14

18 Where was disease contracted?

If not at place of death?

Birmingham Ala.

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) C. Hampton Jones, Jr. M. D.

3/2, 1928 (Address) 1605 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Greenwood Cemetery Mar 5, 28

20 UNDERTAKER ADDRESS George L. Schwab 2101 E. Lake Ave.



1225

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. *Bon Secours Hospital* ST. *11-15* WARD)

FULL NAME

*Charles Vincent Hensley*RESIDENCE No. *712 St Paul*

(Usual place of abode)

ST.

WARD

th of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male white**widower*

HUSBAND of (or) WIFE of

*Nancy Rogers*

DATE OF BIRTH (month, day, and year)

*Mar 22 1856*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*71**11**8*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*a Mgr.*

(b) General nature of industry, business, or establishment in which employed (or employer)

*U. S. F. & G. Co*

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Md*

10 NAME OF FATHER

*Wm Hensley*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Kent Co Md*

12 MAIDEN NAME OF MOTHER

*Anne Wright*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Queen Anne Co Md*

Informant (Address)

*Mrs R. A. Robinson Elbridge Md*

Filed

1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 1 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 11*, 19 *28*, to *Mar 1*, 19 *28*that I last saw him alive on *Mar 1*, 19 *28*, and that death occurred, on the date stated above, at *6 15 P.m.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia**Myocarditis Chronic*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*same*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*Clinical*

(Signed)

*George O. Eaton M. D.*

3/2, 1928 (Address)

*Bon Secours Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*Loudon Park**Mar 5 1928*

UNDERTAKER

*Henry H. Jenkins Sons*

ADDRESS

*McClure Orchard*

1497  
31226

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31226

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 21-29

FULL NAME

Emma Fralini

RESIDENCE NO.

830 Carroll

(Usual place of abode)

Place of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Black

Married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

2-8-28

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

17

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Ind -

10 NAME OF FATHER

Matthews Fralini

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ind -

12 MAIDEN NAME OF MOTHER

Pearl Clark

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ind -

Informant  
(Address)

Friends -

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 24 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 25, 1928, to Feb 24, 1928,

that I last saw her alive on Feb 24, 1928,

and that death occurred, on the date stated above, at 12 - m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

Allan Blossom, M. D.

, 19 (Address)

The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner of Health,

MAR 3 - 1928

31227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 31227

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital Ward 47-48)

2-FULL NAME William D. Mc Adoo

(a) RESIDENCE NO. 5207 York Road St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)  
Length of residence in city or town where death occurred 16 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race white 5 State, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Mc Adoo

DATE OF BIRTH (month, day, and year) March 17, 1885

AGE 42 Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Salesman  
(b) General nature of industry, business, or establishment in which employed (or employer) ob6  
(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) NY  
(State or country) \_\_\_\_\_

10 NAME OF FATHER Wm H Mc Adoo

11 BIRTHPLACE OF FATHER (city or town) NY  
(State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Emma Paine

13 BIRTHPLACE OF MOTHER (city or town) NY  
(State or country) \_\_\_\_\_

14 Informant Jane Mc Adoo  
(Address) 5207 York Road

15 1928 C. HAMPTON JONES, M. D.  
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Ischaemic  
Heart  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_  
(Signed) John H. Jones M. D.  
(Coroner)  
3/2, 1928 (Address) 7632 Roland

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL \_\_\_\_\_ Date of Burial \_\_\_\_\_

20 UNDERTAKER Woodlawn Cem March 1928

Chenoweth ADDRESS 3615 Chestnut

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31228

## CERTIFICATE OF DEATH.

17E 31228

## 1-PLACE OF DEATH

Registered No. ....

City of BALTIMORE: (No. 626 N. Carrollton Av. St. 16-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) Residence No. 626 N. Carrollton Av. St. .... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

## MEDICAL CERTIFICATE OF DEATH.

SEX, Female 4-COLOR OR RACE, C 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day and year) Aug. 8. 1880AGE, 47 yrs. 6 mos. 21 ds. If LESS than 1 day, .... hrs. or .... min.?

## OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laundress.  
(b) General nature of industry, business, or establishment in which employed (or employer). del  
(c) Name of employer. ....BIRTHPLACE (city or town). Ann Arundel Co. Md.  
(State or Country)10-NAME OF FATHER, John Creek11-BIRTHPLACE OF FATHER (city or town). Ann Arundel Co.  
(State or Country)12-MAIDEN NAME OF MOTHER, Martha Peters13-BIRTHPLACE OF MOTHER (city or town). Ann Arundel Co.  
(State or Country)14- (Informant). John Strother (Son)  
(Address). 819 Arlington Ave.15- C. HAMPSON JONES, M. D.

1928

Registrar.

16-DATE OF DEATH (month, day and year). 2-29-2817- I HEREBY CERTIFY, That I attended deceased from Nov. 5 1927, to Feb. 29, 1928.that I last saw her alive on Feb. 29, 1928.and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilatation(Duration) .... yrs. .... mos. 3 ds.CONTRIBUTORY (Secondary) Nephritis(Duration) .... yrs. 4 mos. .... ds.18-Where was disease contracted  
If not at place of death? .....

Did an operation precede death? .... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. M. Lawrence M. D., 19 (Address) 1232 W. Mosher St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR DATE OF BURIAL

St. Luke's Church 3/3, 192820-INTERTAKER, ADDRESS St. Luke's Church



1229

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31229

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: NO.

FULL NAME

RESIDENCE NO.

(Usual place of abode)

Place of residence in city or town where death occurred

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29th 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Aug. 4th 1927 to Feb. 29th 1928.  
that I last saw him alive on Feb. 26th 1928,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:  
Aortic Ins.

(duration) 1 yrs. 6 mos 5 ds. ?

CONTRIBUTORY  
(Secondary)

Arterio sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted  
if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed)

Walter J. Jackson

M. D.

, D (Address)

1631 W. Franklin St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS



# HEALTH DEPARTMENT—CITY OF BALTIMORE

31231

## CERTIFICATE OF DEATH.

66 E 31231  
REGISTERED NO.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 879 W. Fayette St. 18-76 Ward)

### 2-FULL NAME

#### (a) RESIDENCE NO.

(Usual place of abode) Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Divorced

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years Months Days IF LESS than 1 day...hrs. or...min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 9 BIRTHPLACE (city or town)

(State or country)

### 10 NAME OF FATHER

### 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

### 12 MAIDEN NAME OF MOTHER

### 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

### 14

Informant (Address)

### 15

File 1928

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably acute Alcoholism (duration) yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. (Signed) M. D. (Coroner)

3/2, 1928 (Address) 2439 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sx Marys Hayden 3/5 1928

### 20 UNDERTAKER

William Cook ADDRESS 502 E North

E 31232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 31232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4-30* WARD)

2-FULL NAME

*Thomas H Brewer*

(a) RESIDENCE NO.

*East Port Md*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *27* mos. ds.

ST. WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

*M*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced, (write the word)

*M*

If married, widowed, or divorced HUSBAND of (or) WIFE of

*Louis Brewer*

DATE OF BIRTH (month, day, and year)

AGE

*58*

Years

Months

Days

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Brick Mason*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Attd.*

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Md.*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Unknown*

Informant (Address)

*University Hosp. Records*

Filed

1928

*C. H. JONES, M.D.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/3*

19 *28*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 5*

19 *28*

to *Mar 3*

19 *28*

that I last saw him alive on

*3/3*

19 *28*

and that death occurred, on the date stated above, at

*9:50 P m.*

The CAUSE OF DEATH\* was as follows:

*Diabetes Mellitus*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*Cardiac of risk for 1 mo*  
*Phlebitis of left leg 2 days*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

*unk*

Did an operation precede death?

*Yes*

Date of

*2/2/28*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Laboratory + Clinical*

(Signed)

*J. F. Kusby*

M. D.

, 19

(Address)

*University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

NOVAL

*Cedar Bluff Annapolis*

UNDERTAKER

*Geo M. Smith & Son*

DATE OF BURIAL

*Mar 4 1928*

ADDRESS

*811 N Wolfe*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

233

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

2-CITY OF BALTIMORE: (No.

3-FULL NAME

Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

EX-1-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *March 2, 1928*  
(Month) (Day) (Year)

7-AGE, *22* yrs. mos. da. If LESS than 1 day, *22* hrs. or min.

## OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

1928

16-

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*March 3, 1928*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 2, 1928*, to *March 3, 1928*, that I saw her alive on *March 2, 1928*, and that death occurred, on the date stated above, at *3<sup>rd</sup>* m.

The CAUSE OF DEATH<sup>1</sup> was as follows:

*Premature birth*

(Duration)..... yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(Signed)..... M. D.  
*March 3, 1928* (Address) *1845 N. Beulah St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

*Rehearsal Home* *3/4, 1928*

*Jack Lewis 1439 E. Salt St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 1226 E Madison

FULL NAME Elena ThomasRESIDENCE NO. 1226 E Madison

(Usual place of abode)

th of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

Colored5 Single, Married, Widowed,  
or Divorced, (write the word)Marriedmarried, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workHouse work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Va

10 NAME OF FATHER

James Ewell11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Va

12 MAIDEN NAME OF MOTHER

unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)Marion Walker  
1206 E Madison

4 Filed

1928

C. HAMILTON JONES, M. D.

Registrar

REGISTERED NO.

E 31234

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3. 2 - 192817  
HEREBY CERTIFY, That I attended deceased from  
Feb 10, 1928, to March 2, 1928,  
that I last saw her alive on Feb 28, 1928,  
and that death occurred, on the date stated above, at 1 P. m.  
The CAUSE OF DEATH was as follows:Senile marasmus (Senile Decay)  
Resulting arterio sclerosis  
Cardiac & Respiratory failure  
Impaired circulationCONTRIBUTORY Central Hemorrhage  
(duration) 10 yrs. 10 mos. 10 ds.18 Where was disease contracted  
if not at place of death? unknownDid an operation precede death? No Date of -Was there an autopsy? NoWhat test confirmed diagnosis? No(Signed) Maxwell Smith, M. D.19 (Address) 114 N. Carrollton\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALCharles town west Va  
UNDERTAKEREdward Bryan

DATE OF BURIAL

March 5 1928

ADDRESS

1681 Calvert  
St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31235

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 DoverST. 77-30 WARD)2. FULL NAME Mary Johnson(a) RESIDENCE NO. 633 Dover  
(Usual place of abode)Length of residence in city or town where death occurred 7 yrs. mos. ds.ST. 77-30 WARD

REGISTERED NO.

E 31235

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE Male Col 5 Single, Married, Widowed, or Divorced, (write the word) WidowIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of unknownDATE OF BIRTH (month, day, and year) Exact date 8  
AGE Years Months Days If LESS than  
94 7 1 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

BIRTHPLACE (city or town) Md.  
(State or country)10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country) unknown12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) unknown

14

Informant Mary Brandler  
(Address) 633 Dover

15

Filed 1928 19 HARVEY JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 19 2817 I HEREBY CERTIFY, That I attended deceased from Feb 28, 19 28, to Mar 1, 19 28.that I last saw her alive on Mar 1, 19 28,  
and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis(duration) 1 yrs. 1 mos. 5 ds.CONTRIBUTORY (Secondary) Renal Failure(duration) 1 yrs. 1 mos. 5 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? L(Signed) J. H. Jones M. D.(Address) 1349 Madison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Asbury cemeteryDATE OF BURIAL March 520 UNDERTAKER Edward BryanADDRESS 1681

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31236

PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 31236

OF BALTIMORE: (No. 911 Montpelier

ST. 9-46 WARD)

-FULL NAME

Katherine Murray

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE No. 911 Montpelier

(Usual place of abode)

ST. WARD

Age of residence in city or town where death occurred

60 yrs. -- mos. -- ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

male White Widow

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

John Murray

DATE OF BIRTH (month, day, and year) April 3, 1850

AGE Years Months Days If LESS than 1 day, hrs or min.

77 11 0

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore County  
(State or country) Maryland

10 NAME OF FATHER Thomas Keating

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Hanore Hennegan

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Ireland

Informant Mrs. Wm. J. Keating  
(Address) 911 Montpelier Street

15

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3 1928

17

I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1927, to Mar. 3, 1928.

that I last saw her alive on Mar. 2, 1928.

and that death occurred, on the date stated above, at 3.35 A. M.

The CAUSE OF DEATH\* was as follows:

carcinoma of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Morley Hoag, M. D.

3/3, 1928 (Address) 729 Washington Blvd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cemetery

3/5 1928

By UNDERTAKER

ADDRESS

Henry U. Mears &amp; Sons 805 N. Calvert





# HEALTH DEPARTMENT-CITY OF BALTIMORE

E 31238  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH

31 E 31238

ty of BALTIMORE: (No.

REGISTERED NO.

2-FULL NAME

James Edgar ALLEN

St. 18-76 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

924 W. 77th Street

St. Ward

th of residence in city or town where death occurred

(If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 Color or Race

Negro

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

None

DATE OF BIRTH (month, day, and year)

Doesn't know 1906

AGE

Years

22

Months

Days

IF LESS than 1 day hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Transferman

(b) General nature of industry, business, or establishment, in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Richard Allen

11 BIRTHPLACE OF FATHER (City or town) (State or country)

No record

12 MAIDEN NAME OF MOTHER

No record

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

No record

14 Informant (Address)

Hopt Reports

15 Filed, 19

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

77 Jan. 2, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1928, to 77 Jan. 2, 1928,

that I last saw him alive on 77 Jan. 2, 1928,

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:

Ruptured Appendix. Peritonitis

Tuberculosis of Lung

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 25 ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

Date of 2-16-28

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/1/28 19 (Add) M. D. State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Date of Burial

March 5, 1928

ADDRESS

916

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 31239

## CERTIFICATE OF DEATH.

90 E 31239

PLACE OF DEATH

OF BALTIMORE: (No. *705 Arlington ave* ST., *6* WARD)FULL NAME *Harry F. Clubb*RESIDENCE No. *705 Arlington ave* ST., *6* WARD

(Usual place of abode)

Place of residence in city or town where death occurred

*48* yrs.*6* mos.*26* ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*White**Married*Married, widowed, or divorced  
HUSBAND of  
or WIFE of*Luetta Clubb*

DATE OF BIRTH (month, day, and year)

*August 15, 1877*

E

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*48**6**26*

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work*Conductor*b) General nature of industry,  
business, or establishment in  
which employed (or employer)*United Elec. Railway*

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Baltimore*  
*md*

10 NAME OF FATHER

*William Clubb*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Balto*  
*md*

12 MAIDEN NAME OF MOTHER

*Elizabeth Petrel*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore*  
*md*Informant  
(Address)*Luetta Clubb*  
*13550 Old York Road*

Filed

19

*PAUL JONES, M. D.*  
*Alb* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 2nd 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Oct 29th*, 19 *27*, to *March 2nd*, 19 *28*.that I last saw him alive on *March 2nd*, 19 *28*.and that death occurred, on the date stated above, at *9:55 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Coronary Dilatation*CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No*Was there an autopsy? *No*What test confirmed diagnosis? *Calminal Exam*(Signed) *George Schilling M. D.*3/3/28 (Address) *401 E 25th St*  
\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Parkwood Cemetery*

DATE OF BURIAL

*Mar 6th 1928*

20 UNDERTAKER

ADDRESS

*George Schilling & Co 1120 E Monument St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31240

E 31240

## CERTIFICATE OF DEATH.

PLACE OF DEATH

Sinai Hospital

OF BALTIMORE: (No.

FULL NAME

Frank Nadelman

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO.

5309 Milford Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

Married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Mary Nadelman

DATE OF BIRTH (month, day, and year)

GE

Years

Months

Days

If LESS than  
1 day. hrs  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tucker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Russian

10 NAME OF FATHER

Edele D. Nadelman

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Russian

12 MAIDEN NAME OF MOTHER

Sarah

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Russian

Informant  
(Address)Mary Nadelman  
5309 Milford Ave.

Filed

10

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/3

19 28

17

I HEREBY CERTIFY, That I attended deceased from

Jan 27, 1928, to March 3, 1928,  
that I last saw him alive on March 3, 1928

and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? ho Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

Signed)

3/3, 19 28 (Address)

J. M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Hebrew Friendship Cen

DATE OF BURIAL

3/4 19 28

20 UNDERTAKER

Jack Lewis 1439 E. Pratt St



31241

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31241

PLACE OF DEATH

OF BALTIMORE: (No. 32-E. Ostend St

ST. 23-31 WARD)

FULL NAME Howard L. Elder

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE No. 32 E. Ostend St.

ST.

WARD

(Usual place of abode)

th of residence in city or town where death occurred 42 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male White	Married

 married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

Amanda Elder

DATE OF BIRTH (month, day, and year) Sept. 21 1885

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	42	5	10	11

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement Finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER Levy Elder

11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Liza Lillie

13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)

Informant Mrs. Elder

(Address)

32 E. Ostend St.

Filed

1928

HAYDON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 23, 1928, to March 2, 1928,

that I last saw him alive on March 2, 1928,

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH\* was as follows:

Aortic Regurgitation

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted;  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry T. Buettner, M. D.

Mar 2, 1928 (Address) 1319 Light St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill Cem

DATE OF BURIAL

3/6 1928

20 UNDERTAKER

J. F. McCarly

ADDRESS

1308 Front

242

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31242

1-PLACE OF DEATH Vol of America Hospital

CITY OF BALTIMORE: (No. 418 W. Lexington ST. 24-34 WARD)

2-FULL NAME Thos E. Crawford

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1727 Coorington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

EX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Ida. B. Crawford

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

56

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3-28

17

I HEREBY CERTIFY, That I attended deceased from

2-4-28, 19, to 3-3-28, 19,

that I last saw him alive on 3-3-28, 19,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH\* was as follows:

Cancer of urinary bladder

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. &amp; Lab.

(Signed)

M. D.

3-3-28 (Address) 2214 E. Fayette St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

31243

CERTIFICATE OF DEATH

129 E 31243  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 8-17 St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Morris Bowe or Barr

(a) RESIDENCE NO.

1508-7. Bay

St. 8-17 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Morris Bowe

DATE OF BIRTH (month, day, and year) Aug 2 1877 Nov 12 1874

AGE 53 Years 3 Months 6 Days 9 IF LESS than 1 day... hrs. or... min..

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Russia  
(State or country)

10 NAME OF FATHER Harry Bowe  
11 BIRTHPLACE OF FATHER (City or town) Russia  
(State or country)  
12 MAIDEN NAME OF MOTHER  
13 BIRTHPLACE OF MOTHER (city or town) Russia  
(State or country)

14 Informant Hospital Records  
(Address)

15 Filed 4-1928 Per RR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3-28 19

17 I HEREBY CERTIFY, That I attended deceased from 3/2 1928, to 3/3 1928, that I last saw him alive on 3/3/28, 1928, and that death occurred, on the date stated above, at 1:40 P.M.

The CAUSE OF DEATH\* was as follows:  
Hypertension, Arteriosclerosis, Ch.  
Myocarditis, Ch. Nephritis,  
Brachioarteria.  
(duration) yrs. mos. ds.

CONTRIBUTORY arteriosclerosis, Ch.  
(Secondary) nephritis  
arteriosclerosis  
(duration) yrs. mos. ds. 2-3

18 Where was disease contracted  
if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John J. ... M. D.  
3/3 1928 (Address)

\*State the Disease Causing Death, from deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Lawrence Herring Run 3/4 1928

20 UNDERTAKER So. Livins... ADDRESS 1127 E. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31244

## CERTIFICATE OF DEATH.

90 E 31244

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

804 E Lombard ST 3-5

WARD)

## 2. FULL NAME

Nathan M Eudlewsky

(a) RESIDENCE NO.

804 E Lombard

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

30

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

30

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

M

W

5 Single, Married, Widowed, or Divorced, (write the word)

M

If married, widowed, or divorced HUSBAND of (or) WIFE of

Sarah

DATE OF BIRTH (month, day, and year)

AGE

76

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sexton

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Nathan Eudlewsky

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Esther Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

Informant (Address)

Sarah Eudlewsky 804 E Lombard St

15

Filed

1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1928, to March 2, 1928, that I last saw him alive on March 2, 1928, and that death occurred, on the date stated above, at 1:30 m. The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical

(Signed)

H. J. Baylin

M. D.

3/3, 1928 (Address)

210 Prospect St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Rose Dale Unit

DATE OF BURIAL

3/4 1928

20 UNDERTAKER

Sol Swinson &amp; Co

ADDRESS

1127 E Balto St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31245

## CERTIFICATE OF DEATH.

90 E 31245

PLACE OF DEATH

OF BALTIMORE: (No. 806 W Lombard

ST. 18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME CATHERINE AGLINSKAS

RESIDENCE No. 806 W Lombard

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

th of residence in city or town where death occurred 29 yrs. mos.

ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

F

W

Married

married, widowed, or divorced

HUSBAND of

(or) WIFE of

Catherine Aglinskis

DATE OF BIRTH (month, day, and year)

No. 1873

AGE 55 Years Months Days

Days

If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Lithuania (State or country)

10 NAME OF FATHER Antony Masandukas

11 BIRTHPLACE OF FATHER (city or town) Lithuania (State or country)

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) Lithuania (State or country)

Informant A. Aglinskis

(Address) 806 W Lombard Street

Filed

1978 HAMMON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 1, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1928, to Mar. 1, 1928,

that I last saw him alive on Mar. 1, 1928

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH\* was as follows:

Cardiac Dilatation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed)

Theodore C. Blake

M. D.

73. 1929. (Address) 714 Med. Art. Bldg.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislawas

March 5, 1928

20 UNDERTAKER

ADDRESS

Charles B. Kuchauskas

337 S. Paca St.

31246

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31246

PLACE OF DEATH

Y OF BALTIMORE: (No.

1118 - 13

2-FULL NAME ANTHONY WABALAS

(a) RESIDENCE NO. 1118 - 13

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 16, 1919

AGE

9

Years

Months

4

Days

16

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md.  
(State or country)

10 NAME OF FATHER Antony Wabalas

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Mary Klinavskas

13 BIRTHPLACE OF MOTHER (city or town) Lithuania  
(State or country)Informant Antony Wabalas  
(Address) 1118 13th Street

14 Filed 1928 C. HAMPTON JONES, H. B.

Registrar

ST. 25-72 WARD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1928, to March 2, 1928.

that I last saw him alive on March 1, 1928.

and that death occurred, on the date stated above, at 12.40 A. M.

The CAUSE OF DEATH\* was as follows:

Symptomatic Leukemia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No

Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Blood Findings  
(Signed) Wm. A. Strauss M. D.  
3/2, 1928 (Address) 1201 Guffey Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer

DATE OF BURIAL

UNDERTAKER

Chas. B. Kuchauskas

ADDRESS

1118 13th St

E 31247

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

E 31247

1-PLACE OF DEATH

City of BALTIMORE: (No. 42-50 St. 42-50 Ward)

2-FULL NAME Anna Bates

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 203 Hopkins apt St. 42-50 Ward

(Usual place of abode)

Length of residence in city or town where death occurred life mos. 1 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of John Bates

DATE OF BIRTH (month, day, and year) 6-17-1844

AGE Years 78 Months 8 Days 14 IF LESS than 1 day hrs. or min..

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md.

10 NAME OF FATHER John Griffith

11 BIRTHPLACE OF FATHER (City or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Anna Kinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Hop. Kinn (Address)

15 Filed 4-19-28 W. H. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2-28 19

17 I HEREBY CERTIFY, That I attended deceased from 7-11-24 19, to 3-2-28 19, that I last saw her alive on 3-2-28 19, and that death occurred, on the date stated above, at 2<sup>10</sup> A.M.

The CAUSE OF DEATH\* was as follows: Epithelioma of Skin of Rt side of Back (Primary)

CONTRIBUTORY Dist. Circumstances (duration) 15 yrs. 2 mos. 4 ds. (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical (Signed) C. E. Zimmerman M. D.

3/2 . 19 28 (Address) 203 Hopkins

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Greenmount Cemetery Date of Burial Mar. 5 19 28

20 UNDERTAKER W. H. D. ADDRESS 1003 W. Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31248

31248

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *1-13* WARD)FULL NAME *Thomas Kane*RESIDENCE No. *2211 Gough*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *✓*DATE OF BIRTH (month, day, and year) *Oct 30-1887*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*40**4**1*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Fin Decorator*(b) General nature of industry, business, or establishment in which employed (or employer) *Fin Decorator*(c) Name of employer *Plant 53*BIRTHPLACE (city or town) (State or country) *city*10 NAME OF FATHER *Thos. Kane*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Ellen Kane*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*Informant (Address) *Marion Kane*

R 4 - 1928. HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/1/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *2/26/*, 19 *28*, to *3/1/*, 19 *28*.that I last saw him alive on *3/1/28*, 19and that death occurred, on the date stated above, at *1:15 P. m.*

The CAUSE OF DEATH\* was as follows:

*lobar pneumonia*(duration) yrs. mos. *4* ds.CONTRIBUTORY (Secondary) *cardiac dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Henry G. Vont*, M. D.

, 19

(Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

*J. A. Moran*ADDRESS *3/1/28**Bellevue*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31249

E 31249

PLACE OF DEATH

OF BALTIMORE: (No. 1810 McCulloh

ST. 14-70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME William Taylor

a) RESIDENCE NO. 1810 McCulloh

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs.

mos. ds.

ST., WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Single

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 1904

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

24 1 0

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER Joseph Taylor

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER Emma Thomas

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

File 1928C

H. M. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 2 - 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 1, 1928, to March 2 - 1928,

that I last saw him alive on March 2 - 1928,

and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Broncho Pneumonia +  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive

(Signed) R. W. H. M. D.

23, 1928 (Address) 708 E. Union St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Berkely Va.

3/5/ 1928

20 UNDERTAKER

ADDRESS

Mrs. Geo. H. Holland 1681 Duval  
Hill Ave

# 1250 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

71279  
E 31230

PLACE OF DEATH

OF BALTIMORE: (No. 2029 E. Eager.

ST. 7-13 WARD

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME William Kurka.

RESIDENCE NO. 2029 E. Eager (Usual place of abode)

ST. WARD

Age of residence in city or town where death occurred 44 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married.

Married, widowed, or divorced HUSBAND of (or) WIFE of Cecilia Kurka.

DATE OF BIRTH (month, day, and year) May 11, 1883. Years 4. Months 9 Days 21. If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) City Department

(c) Name of employer

BIRTHPLACE (city or town) Baltimore City. (State or country) Maryland.

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country)

12 MAIDEN NAME OF MOTHER Not known.

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

Informant Cecilia Kurka. (Address) 2029 E. Eager St.

Filed 1928 JONAS, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1928.

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1928, to March 3, 1928, that I last saw him alive on March 3, 1928, and that death occurred, on the date stated above, at 4 50 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis.

CONTRIBUTORY (Secondary) (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests Physical evidence

(Signed) a. Mrs. B. Dybert, M. D.

, 19 (Address) 2402 Harford Ave

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Cemetery

20 UNDERTAKER August Psek 2406 E. Ashland Ave.

DATE OF BURIAL

March 6, 1928.

ADDRESS

31251

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31251

## CERTIFICATE OF DEATH.

PLACE OF DEATH :

OF BALTIMORE: (No. 2212 East Eager Place 7-12 WARD)

FULL NAME Michael Stupka

RESIDENCE No. 2212 East Eager Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

6 HUSBAND of or WIFE of Stelia Stupka

7 DATE OF BIRTH (month, day, and year) Feb 7 1875

8 Years Months Days 23 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work Tailor 80

b) General nature of industry, business, or establishment in which employed (or employer) at home

c) Name of employer

9 BIRTHPLACE (city or town) Bohemia

State or country

10 NAME OF FATHER Thomas Stupka

11 BIRTHPLACE OF FATHER (city or town) Bohemia

(State or country)

12 MAIDEN NAME OF MOTHER not know

13 BIRTHPLACE OF MOTHER (city or town) Bohemia

(State or country)

Informant Stelia Stupka

(Address) 2212 E. Eager Place, W. 7

Filed 1928 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1928, to March 3, 1928, that I last saw him alive on March 2, 1928, and that death occurred, on the date stated above, at 2:15 a.m. The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
Tuberculosis Sanguinis

(duration) 2 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Sputum & X-ray

(Signed) Joseph Pokorny, M. D.

(Address) 2200 E. Madison St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

2400  
Ashland  
ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 31252

31252

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

2406 Southern Ave ST. 27-44 WARD)

## 2. FULL NAME

Michael J. Upton

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2406 Southern Ave ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Life yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Nov. 1, 1876

AGE

Years

51

Months

3

Days

0

If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

Western Union

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

13 Baltimore

10 NAME OF FATHER

William C. Upton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Catherine Ahern

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

Informant (Address)

Mrs. Annie Long

2406 Southern Ave

Filed

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 29, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1928, to Feb. 29, 1928,

that I last saw him alive on Feb. 29, 1928,

and that death occurred, on the date stated above, at 8:12 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

None

(Signed)

Chas. F. A. Stevens

M. D.

7/29, 1928 (Address)

2875 Harford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

3/5 1928

UNDERTAKER

ADDRESS

George J. Ruth 1735 Harford Ave



31253

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 E 31253

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 38 S. Carey

2-FULL NAME Peter J. Nelson

(a) RESIDENCE NO. 38 S. Carey St

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs.

mos.

ST. 19-29 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE Male White

5 Single, Married, Widowed, or Divorced, (write the word) Single

(If married, widowed, or divorced HUSBAND of (or) WIFE of)

DATE OF BIRTH (month, day, and year) July 1861

AGE 66 Years Months Days

67 8

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bartlett &amp; Hayward

BIRTHPLACE (city or town) New York

(State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

Informant (Address) Mrs Anna Emma

38 S. Carey St

Filed

5-1928

C. HARRISON JONES, M. D.

How long in U. S., if of foreign birth? ds. yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21 1928

17

I HEREBY CERTIFY, That I attended deceased from 1/15/1928 to 3/21/1928

that I last saw him alive on 3/21/28

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Malignant Tumor

Glandular Act. Scleroma

Myocardial Infarct

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray etc

(Signed) Edward J. Ferry

3/3/1928 (Address) 910 W. Lombard

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

London Park Cem

UNDERTAKER

Robert Brooks &amp; Son

DATE OF BURIAL

3/5 1928

ADDRESS

Cathonia Hollins

HEALTH DEPARTMENT—CITY OF BALTIMORE

31254

CERTIFICATE OF DEATH

REGISTERED NO.

E 31254

1-PLACE OF DEATH *Sydenham Hospital*

City of BALTIMORE: (No. *Stanford Ave + Harry Run* St. *18-76* Ward)

2-FULL NAME *Margaret Turner*

(a) RESIDENCE NO. *904 W. Fayette*

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX *F.* 4 Color or Race *B.* 5 Single, Married, Widowed, or Divorced, (write the word) *child*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *March 8, 1927*

AGE Years Months Days *11 29* IF LESS than 1 day hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *Baltimore, Md*

10 NAME OF FATHER *Thomas Turner*

11 BIRTHPLACE OF FATHER (City or town)

(State or country) *Eastern Shore, Va.*

12 MAIDEN NAME OF MOTHER *Mary Moore*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Eastern Shore, Va.*

14

Informant (Address)

*Sydenham Hosp.*

15 Filed

*1928* *H. J. Jones, M. D.* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 4 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 26*, 1928, to *March 4*, 1928,

that I last saw him alive on *March 4*, 1928,

and that death occurred, on the date stated above, at \_\_\_\_\_

The CAUSE OF DEATH\* was as follows:

*Acute Myocarditis (Right Ventricle)*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *1. Latent Right Heart Failure 2. Broncho pneumonia*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *S. S. Bachman*, M. D.

19 (Address) *Sydenham Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mt Auburn Cem.*

Date of Burial

*3-5 1928*

20 UNDERTAKER

*Bartholomew Easter*

ADDRESS

*916 P. ...*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31255  
REGISTERED NO.31255  
PLACE OF DEATHCity of BALTIMORE: (No. Sydenham Hospital St. 1074 Ward)2-FULL NAME Marta Mc Gee(a) RESIDENCE NO. 721 East Chase St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) SingleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Oct. 24, 1922AGE Years 5 Months 4 Days 8 IF LESS than 1 day hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis(State or country) Maryland10 NAME OF FATHER Andrew Mc Gee11 BIRTHPLACE OF FATHER (City or town)  
(State or country)12 MAIDEN NAME OF MOTHER Marta Nichols13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant Mrs. Andrew Mc Gee  
(Address) 721 East Chase St.15 Filed 5-1928 G. HARRISON JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 19 2817 I HEREBY CERTIFY, That I attended deceased from Mar. 3, 19 28, to March 3, 19 28,that I last saw her alive on March 3, 19 28,and that death occurred, on the date stated above, at 10<sup>05</sup> p. m.

The CAUSE OF DEATH\* was as follows:

Diphtheria - Toxic  
Pharyngeal & Laryngeal(duration) yrs. mos. 2 ds.CONTRIBUTORY Acute myocarditis  
(Secondary) (Toxic)(duration) yrs. mos. 7 ds.

18 Where was disease contracted

if not at place of death? At homeDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Bacteriological  
(Signed) L. L. Levin, M. D.Mar 4, 1928 (Address) Sydenham Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mc Clellan3/5 19 28

20 UNDERTAKER

ADDRESS

Wm. Cook502 E. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31256

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926

ST., 2nd WARD

## 2. FULL NAME

David ~~Garrettson~~ Garrettson

(a) RESIDENCE NO. 1926

ST., 2nd WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Mar 3 1926

AGE

Years

Months

Days

3 hours

If LESS than  
1 day 3 hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore Md.

10 NAME OF FATHER

Jerrald H. Nelson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

The Virginia Carter

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore

14

Informant  
(Address)

Jerrald H. Garrettson

15

PWed

1928 G. HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 3, 1928, to Mar 4, 1928.

that I last saw him alive on Mar 3, 1928.

and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH\* was as follows:

enlarged Foramen ovale

(duration) yrs. mos. ds.

CONTRIBUTORY Premature Birth  
(Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. D. M. D.

, 19 (Address) 118 S. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mount Olivet

Mar 5 1928

Louis Heemann 321 Drexel



HEALTH DEPARTMENT—CITY OF BALTIMORE

31257

CERTIFICATE OF DEATH.

167 E 31257

1-PLACE OF DEATH

City of BALTIMORE: (No. *Colonial Hospital 4-20* St., *4-20* Ward)

2-FULL NAME

*Marilyn Robinson*

(a) RESIDENCE NO.

*608 Monks St.*

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. - mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male Col*

*Widow*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*1880*

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

*48*

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Janitor - 670*

BIRTHPLACE (city or town)

(State or country)

*Washington D. C.*

NAME OF FATHER

*John Robinson*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*D.C.*

12 MOTHER NAME OF MOTHER

*Sarah A. Shouler*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Va*

14

Informant (Address)

*Thomas H. Robinson Washington D. C.*

15 Filed

*MAR 5 - 1926*

*WILLIAMSON JONES, M.*

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*MAR 3 1926*

17 I HEREBY CERTIFY That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

hereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*Suicide Gas Poisoning Ill.*

CONTRIBUTORY (Secondary)

*Asphyxia*

*Mar 4/26*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Wash D.C.*

UNDERTAKER

*Hein Easton*

Date of Burial

*3/5 1926*

ADDRESS

*916 12th Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31258

31258

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST., 3-4 WARD)FULL NAME Marie D. Anderson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE No. 407 S. Dulaney ST., WARD

(Usual place of abode)

Place of residence in city or town where death occurred

P.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male coloredmarriedMarried, widowed, or divorced  
HUSBAND of  
(or) WIFE of

?

DATE OF BIRTH (month, day, and year)

?

E.

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.48

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of worknoneb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)in England

10 NAME OF FATHER

Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Emily Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

Informant

(Address)

Records

Filed

19

1928 RECORDED INDEXED  
1928 RECORDED INDEXED  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/1928

17

I HEREBY CERTIFY, That I attended deceased from  
Apr. 30, 1927, to March 1, 1928  
that I last saw he alive on March 1, 1928  
and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. mos. 6 ds.CONTRIBUTORY temperatures - recd.  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sub(Signed) C. J. Brown, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVA

DATE OF BURIAL

at Auburn March 19

20 UNDERTAKER

ADDRESS

Chas. L. Brown 108 Mont

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31259

## CERTIFICATE OF DEATH

E 31259

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 612 S Fremont St. 21-29 Ward)2-FULL NAME Walter Shager(a) RESIDENCE NO. 612 S Fremont St. Ward 21

(Usual place of abode)

Length of residence in city or town where death occurred—yrs. 8 mos. —da.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 Color or Race

Col

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

1898

AGE

Years

Months

Days

30IF LESS than  
1 day.....hrs.  
or.....min..

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Curing Dept

(c) Name of employer

C. S. Reed

9 BIRTHPLACE (city or town)

Eastman

(State or country)

Georgia

10 NAME OF FATHER

William

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

William

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)Daniel Payne612 S Fremont

15 Filed

5-1928

16

WILLIAM JONES, M. D.

Registrar

101-001

REGISTERED NO.

21-29

21

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/2 1928

17

I HEREBY CERTIFY, That I attended deceased from

2/27, 1928, to 3/2, 1928,that I last saw him alive on 3/1, 1928,and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH\* was as follows:

Acute Fobar pneumonia(duration) — yrs. — mos. 8 da.

CONTRIBUTORY

(Secondary)

(duration) — yrs. — mos. — da.

18 Where was disease contracted

: if not at place of death? —

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) D. W. Jones, M. D.3/4, 1928 (Address) 142 N. Lee St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

1400March 5, 1928

20 UNDERTAKER

S. L. Brantson

ADDRESS

108 Mont

31260

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

40 E 31260

## PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE No.

(Usual place of abode)

Place of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

E

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed 1928

19

C. H. JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

4/18/28

to

3/4/28

19

that I last saw her alive on

3/4/28

19

and that death occurred, on the date stated above, at 3:25 A.M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Yes

Date of

2/24/28

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical signs

(Signed)

1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31261

## CERTIFICATE OF DEATH.

PLACE OF DEATH *Kehren Home for Aged*  
OF BALTIMORE: (No. *2100 E. Baltimore* ST., *6-10* WARD)FULL NAME *Sarah Rosenberg*RESIDENCE NO. *2100 E. Baltimore* ST.,

(Usual place of abode)

Age of residence in city or town where death occurred *40* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *40* yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Louis Rosenberg*

DATE OF BIRTH (month, day, and year)

YE

*74*

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*  
*037*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Russian*

10 NAME OF FATHER

*Unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Russian*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Russian*Informant  
(Address)*Jack Lewis*  
*1439 E. Baltimore*

Filed

*5-10-28**HARRISON JONES, M. D.*  
*R. J.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/4 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*January, 1928, to March 4, 1928.*that I last saw her alive on *March 3, 1928.*and that death occurred, on the date stated above, at *8 a* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial infarction*(duration) *2* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Swobbert*, M. D., 19 (Address) *1915 E. Baltimore*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MORAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Kehren Southern Co.*  
*Jack Lewis 1439 E. Baltimore*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

262

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

Y OF BALTIMORE: (No. 3047. Fusby

ST. 9-46 WARD)

FULL NAME

Harry C. Soistman

(a) RESIDENCE NO.

3047. Fusby

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

White

Married

Married, widowed, or divorced

HUSBAND of (or) WIFE of

Marie Soistman

DATE OF BIRTH (month, day, and year)

Jan 10 - 1883

AGE

Years

Months

Days

If LESS than

15

1

23

1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Soistman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Lindia Ficke

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't know

4 Informant (Address)

Marie Soistman 12 S. Fremont Ave

5 Filed

C. HARRISON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 13 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 27 1928, to March 3 1928.

that I last saw him alive on March 3 1928.

and that death occurred, on the date stated above, at 2:25 a. m.

The CAUSE OF DEATH\* was as follows:

Nobar pneumonia,

entire left lung

(duration) yrs. - mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) E. H. Hoffman, M. D.

19 (Address) 18 East Read St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

March 19 28

UNDERTAKER

ADDRESS

Robt J Turner Jr

1442 Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31263

## CERTIFICATE OF DEATH

E 31263

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 611 S. Thirteenth St., 26 Ward)2-FULL NAME David Kathleen Turcia(a) RESIDENCE NO. 611 S. Thirteenth St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. 4 mos. / ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years 1 Months 4 Days 1 IF LESS than 1 day.....hrs. or.....min..

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.  
(State or country)10 NAME OF FATHER Van Turcia11 BIRTHPLACE OF FATHER (City or town) Romania  
(State or country)12 MAIDEN NAME OF MOTHER Margt. L. Gallagher13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.  
(State or country)14 Informant Van Turcia (Father)  
(Address) 611 S. 13th St.15 Filing Date 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from February 13, 1928, to March 3rd, 1928.that I last saw her alive on March 3rd, 1928, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH\* was as follows:

Acute Broncho Pneumonia

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No - Date ofWas there an autopsy? No -

What test confirmed diagnosis?

(Signed) Wm. J. Schenck

. 19

(Address) West Eastern Ave City

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mount Carmel Cemetery Md. 5 1928

20 UNDERTAKER

ADDRESS

Lilly & Ziller Inc.403 S. Wolfe St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31264

## CERTIFICATE OF DEATH.

E 31264

## PLACE OF DEATH

OF BALTIMORE: (No. 1120 d. Gilmore

ST. 16-22 WARD)

## FULL NAME Jacob Jackson

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## RESIDENCE NO. 1120 d. Gilmore

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

th of residence in city or town where death occurred 37 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

married, widowed or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Informant

(Address)

Filed

1928

HARRISON JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
before 1927 to February 1928.  
that I last saw him alive on Feb 25, 1928,  
and that death occurred, on the date stated above, at 9:40 p.m.

The CAUSE OF DEATH\* was as follows:

Senile decay  
(Senilis marasmus)CONTRIBUTORY  
(Secondary)

Failure

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31265

31265

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *915 Eastern Ave* ST. *3-5* WARD)2. FULL NAME *Albert Jernetta*(a) RESIDENCE NO. *915 Eastern Ave* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *3* mos. *16* ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Infant*6 If married, widowed, or divorced HUSBAND of (or) WIFE of *Infant*7 DATE OF BIRTH (month, day, and year) *March 19-27*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *3 16 15*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Infant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) *Baltimore*9 NAME OF FATHER *Albert Jernetta*10 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*11 MAIDEN NAME OF MOTHER *Clementine Bruner*12 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*13 Informant (Address) *Virginia Bruner 915 Eastern Ave*

14

15 Filed *1928**1928*

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 2 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 2, 1928* to *March 2, 1928*, that I last saw him alive on *March 2, 1928*, and that death occurred, on the date stated above, at *12:30 p.m.* The CAUSE OF DEATH\* was as follows:*Branchio-Pneumonia*CONTRIBUTORY (Secondary) *Infantile Scabies*

(duration)

yrs.

mos. *3*

ds.

18 Where was disease contracted if not at place of death?

(duration)

yrs.

mos. *3*

ds.

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Joseph S. Valentini, M. D.*1928 (Address) *1450 Perry*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Redeemer*

DATE OF BURIAL

20 UNDERTAKER *Frank V. Cipitoni*ADDRESS *2618 E. Baltimore*



31266

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001  
E 31266

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 503 N-Wolfe St. 6 Ward)2-FULL NAME Edward F. Simpson(a) RESIDENCE NO. 503 N-Wolfe St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) WidowedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Ellen SimpsonDATE OF BIRTH (month, day, and year) December 25, 1846AGE Years 81 Months 2 Days 8 IF LESS than 1 day.....hrs. or.....min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Retired(b) General nature of industry, business, or establishment in which employed (or employer). Clerk

(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) \_\_\_\_\_

(State or country) Philadelphia Pa10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_

(State or country) Pa12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_

(State or country) Pa14 Informant Mrs. Mary D. Miller  
(Address) 503 N-Wolfe St15 Filed 1928 C. HANCOCK JONES, Jr. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 2, 1928, to March 4, 1928,  
at I last saw him alive on March 3, 1928,  
and that death occurred, on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH\* was as follows:

Arterio-SclerosisCONTRIBUTORY  
(Secondary) Central Hemorrhage

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

18 Where was disease contracted

If not at place of death \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Edward J. Leary, M. D.  
3/4, 1928 (Address) 413 N Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial 3/7, 192820 UNDERTAKER Philip HenryADDRESS 2016



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31267

E 31267

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE NO.

(Usual place of abode)

th of residence in city or town where death occurred

73 yrs.

4 mos.

1 ds.

How long in U. S., if of foreign birth?

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male White

Married

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Phillip Weyforth

TE OF BIRTH (month, day, and year)

YE

Years

Months

Days

If LESS than  
1 day... hrs  
or min.

73

4

1

OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work

Housewife

b) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md

10 NAME OF FATHER

Geo. F. Lotz

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

"

Informant  
(Address)Mr. Phillip Weyforth  
6017 Park Heights Ave

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 2 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 20

1928, to

March 2, 1928.

that I last saw her alive on

March 2, 1928.

and that death occurred, on the date stated above, at

10.30 P. m.

The CAUSE OF DEATH\* was as follows:

~~Erysipelas~~  
Erysipelas

about 12 days

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

to physical

(Signed)

Walter E. Hibbert

M. D.

19

(Address)

2220 Garrison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Druid Ridge Cem.

Mar 5 1928

Wm. McKee Jones

North &amp; Pa

## HEALTH DEPARTMENT—CITY OF BALTIMORE-001 ✓

1268

## CERTIFICATE OF DEATH.

E 31268

## PLACE OF DEATH

OF BALTIMORE: (No. *Mercy Hospital* ST. *25-72* WARD)

## FULL NAME

RESIDENCE (No. *Mt. St Agnes* ST. \_\_\_\_\_ WARD \_\_\_\_\_)

(Usual place of abode)

h of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male *White* MarriedMarried, widowed, or divorced  
HUSBAND of  
or WIFE of*Mary A Shea*

TE OF BIRTH (month, day, and year)

E

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*about**65*

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
State or country

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant  
(Address)

Filed

5-1928

HARRISON JONES, M. D.

Per

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 2 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*2/29/28*, 19, to *3/2/28*, 19,that I last saw him alive on *3/2/28*, 19,and that death occurred, on the date stated above, at *11:22* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*(duration) *Indefinite* ds.CONTRIBUTORY  
(Secondary)*Lobar Pneumonia*(duration) yrs. mos. *7* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Clinical*  
*G. E. Winstead*, M. D.*3/2, 1928* (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Mt St Agnes Cemetery* *March 6 1928*

20 UNDERTAKER

ADDRESS

*Henry Jenkins & Co. Inc* *1401 N. E. St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 31269

## CERTIFICATE OF DEATH.

E 31269

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE NO.

(Usual place of abode)

th of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Caucasian white

child

married, widowed, or divorced

HUSBAND of

(or) WIFE of

TE OF BIRTH (month, day, and year)

E.

Years

Months

Days

If LESS than 1 day, hrs.

or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant

(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 5 1928 to March 4 1928.

that I last saw her alive on March 3 1928.

and that death occurred, on the date stated above, at 12:03 a.m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

Disease of New Born

(duration) yrs. 1 mos. 12 ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? No Date of -

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed)

Allan Blossom

M. D.

, 19

(Address)

The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

The Olivet Cemetery

Feb 6 1928

20 UNDERTAKER

A. J. Michael

ADDRESS 711 E. Baltimore Ave.

5-1928

JAMES H. JONES, M. D.

Registrar

*Geo Harris*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31270

## CERTIFICATE OF DEATH.

31 E 31270

## 1-PLACE OF DEATH

 of BALTIMORE: (No. *418 Colm* St. *5-8* Ward)

## 2-FULL NAME

 (a) RESIDENCE NO. *418 Colm* St. *5-8* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

 EX 4 Color or Race *Col* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

 AGE Years Months Days IF LESS than  
1 day.....hrs.  
or.....min. *27* *1901*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Cape Verde Island*12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Cape Verde Island*

14

Informant  
(Address)

15

Filed

1928

16

HARRISON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 3 1928*
 17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*  
(Inquest, autopsy or inquiry.)

 thereon and from the evidence obtained by said *inquest*  
(Inquest, autopsy or inquiry.)

 and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pulmon. tuberculosis*  
(duration) .....yrs. ....mos. ....ds.
CONTRIBUTORY  
(Secondary)
 (Signed) *[Signature]* M. D.  
(Coroner)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Asbury Cemetery Mar. 5 1928*  
20 UNDERTAKER *Chris. H. Johnson* ADDRESS *418 Colm St.*



# 31271 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. *St. Joseph's Hospital 5-8* ST., *5-8* WARD)

FULL NAME *Isaiah Jones*

RESIDENCE NO. *1418 E. Lexington* ST., *6* WARD

(Usual place of abode)

th of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *Male Negro*

5 Single, Married, Widowed, or Divorced, (write the word) *Married*

married, widowed, or divorced HUSBAND of (or) WIFE of *Elizabeth Jones*

TE OF BIRTH (month, day, and year) *1897*

YE

Years *31*

Months

Days

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *D.C.*

10 NAME OF FATHER *Jack Jones*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *D.C.*

12 MAIDEN NAME OF MOTHER *Erema Davis*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *D.C.*

Informant (Address) *Elizabeth Jones*

Filed

1928

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/3/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *3/1/28*, 19 to *3/3/28*, 19 that I last saw him alive on *3/3/28*, 19 and that death occurred, on the date stated above, at *1:10 P. m.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*

(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary) *cardiac dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *T. P. Thompson*, M. D.

, 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

*Bowman S. C. Mar. 7*

1928

2 UNDERTAKER

ADDRESS

*Chas. N. Johnson 416 N. Caroline St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31272

CERTIFICATE OF DEATH.

118-002  
E 31272

1-PLACE OF DEATH

of BALTIMORE: (No. 911 Shields Place 17-24 Ward)

2-FULL NAME

Betty Mitchell

(a) RESIDENCE NO.

911 Shields Place

Ward

(Usual place of abode)

length of residence in city or town where death occurred

ys.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

ys.

mos.

29 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 25, 1928, to March 4, 1928,

that I last saw her alive on March 3, 1928,

and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH\* was as follows:

Intestinal obstruction

(duration) .....yrs. ....mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death:

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Ernest C. Milton, M. D.

, 19 (Address) 2001 Penna. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

R 3-1928

FILED

REGISTERS

Ms. Geo. H. Holland 1601 Duval

E 31270 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31273

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

OF BALTIMORE: (No. 1838 McCulloh

ST., 14-20 WARD)

FULL NAME

Frances Regina Lewis

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO. 1838 McCulloh

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred

yrs. 2 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

male Colored Single  
married, widowed, or divorced  
HUSBAND of  
(a) WIFE of

DATE OF BIRTH (month, day, and year)

Jan 13 - 28

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

one 20

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Md.

10 NAME OF FATHER

David Lewis

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Carrie Jones

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Va

Informant  
(Address)David Lewis  
1838 McCulloh St

Filed

1928

C. HAYDON JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar. 3, 1928, to Mar. 4, 1928,  
that I last saw her alive on Mar. 4, 1928,  
and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Postre

(Signed) Dr. W. H. Kernald M. D.

3-5, 1928 (Address) 708 Enoch St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

UNDERTAKER

M. T. Auburn  
No. 10, St. Holladay

DATE OF BURIAL

3/6/1928  
ADDRESS

E 31274

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

75-001

E 31274

1-PLACE OF DEATH

City of BALTIMORE: (No. 1317 Whitcomb Ward)

2-FULL NAME

(a) RESIDENCE NO. 1317 Whitcomb St. 13 Ward 13

(Usual place of abode)

Age of residence in city or town where death occurred 25 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

4 Color or Race Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Ally Stewart

DATE OF BIRTH (month, day, and year) Dec 3 1899

AGE 18 Years 69 Months 3 Days 0

IF LESS than 1 day 0 hrs. 0 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

BIRTHPLACE (city or town) St. Marys Co. Md.

(State or country)

10 NAME OF FATHER W. T. Mullin

11 BIRTHPLACE OF FATHER (city or town) St. Marys Co.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14

Informant (Address) James Carter

15 Filed 5-1928

W. J. Jones, Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1927, to Mar 3, 1928.

that I last saw him alive on Mar 3, 1928.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Stem plegia & Apoplexy

(duration)

CONTRIBUTORY Subacute Bronchitis

(Secondary)

(duration)

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of 24

Was there an autopsy? No

What test confirmed diagnosis: Stomach (Signed) W. H. Wright, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

UNDERTAKER James E. Wright

ADDRESS 1317 Whitcomb



31273

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31273

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 1023 N. Bond ST. 7-13 WARD)

FULL NAME Mary, C. Brown

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO. 1023 N. Bond ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

th of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

male White

Married

married, widowed, or divorced

HUSBAND of

(or) WIFE of

Walter S. Brown

DATE OF BIRTH (month, day, and year)

May 10/1889

E

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

9

24

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

At Home

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

James Kirkpatrick

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Elizabeth Brady

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

Informant

(Address)

Dea B. Mc Crone.

1023 N. Bond

Filed

5-1928

G. HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4-1918

17

HEREBY CERTIFY, That I attended deceased from

May 10, 1918, to March 4, 1918

that I last saw him alive on March 4, 1918

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH\* was as follows:

Diffuse Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

1918 Address 1501 E. Bay View

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

3-8-1918

20 UNDERTAKER

ADDRESS

Wm. Booth

502 E. North

J.F.A.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31276

## CERTIFICATE OF DEATH.

86-002  
E 31276

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

(a) RESIDENCE, No.

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST., WARD.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 23, 1928, to March 4, 1928,  
that I last saw him alive on March 4, 1928,  
and that death occurred, on the date stated above, at 8:25 A. M.

The CAUSE OF DEATH\* was as follows:

Dysentery

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of Feb. 23.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

C. HAMPTON JONES, M. D.

Stewart &amp; Momen Co. Balt.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31277

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.

1810 Harlem Avenue

ST.

WARD)

FULL NAME

William Henry Kroneberger

RESIDENCE NO.

1810 Harlem Avenue

ST.

WARD

Resident

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

40

yrs.

0

mos.

0

ds.

How long in U. S., if of foreign birth?

74

yrs.

3

mos.

5

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Widowed

Married, widowed, or divorced

HUSBAND of

(or) WIFE of

Martha J. Kroneberger

DATE OF BIRTH (month, day, and year)

Dec-1-1893

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

74

5

3

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

Insurance

(c) Name of employer

Security Life Ins. Co.,

BIRTHPLACE (city or town) (State or country)

Petersburg

Va.

10 NAME OF FATHER

Charles J. Kroneberger

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Wilhelmina Dorr

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

Germany

Informant

Mr. William H. Kroneberger (son)

(Address)

1810 Harlem Ave.

Filed

1928

C. H. JONES, JR., M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 3<sup>rd</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 24<sup>th</sup>

1928

to Mar 3<sup>rd</sup>

1928

that I last saw him alive on

Mar 2<sup>nd</sup>

1928

and that death occurred, on the date stated above, at

4 A.

m

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration)

yrs.

mos

7

ds.

CONTRIBUTORY (Secondary)

Maemia

(duration)

yrs.

mos.

3

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Clinical

(Signed)

Bernard P. Jones, M. D.

1928 (Address)

707 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Loudon Park Cemetery

Mar-5-28

19

20 UNDERTAKER

ADDRESS

STEWART &amp; MOWEN COMPANY

(WILLIAM F. WOODS, Successor)

108 W. NORTH AVE.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31278

E 31278

## CERTIFICATE OF DEATH.

PLACE OF DEATH *Balto City Hospt.*OF BALTIMORE: (No. *Balto Md.* ST. *16-23* WARD)FULL NAME *Harriet Turner*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE No. *1216 Riggs Ave.* ST. WARD

(Usual place of abode)

Place of residence in city or town where death occurred

*40* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

1 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male Black**widow*

Married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Charles Turner*DATE OF BIRTH (month, day, and year) *unknown, 1858*

E

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

*Domestic*

BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Maryland*

Informant (Address)

*Balto City Hospt*

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-2-1928*

17

I HEREBY CERTIFY, That I attended deceased from

*11-19-1927* to *3-2-1928*

that I last saw her alive on

*3-2-1928*and that death occurred, on the date stated above, at *3:45 P. m.*

The CAUSE OF DEATH\* was as follows:

*Terminal Broncho Pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Psychosis of Cerebral Arterio Sclerosis*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*Unknown*Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Harold A. ... M. D.*

Address

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Wm. H. Chase & Co.*

31279

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31279

## CERTIFICATE OF DEATH.

PLACE OF DEATH

2001 Park Ave

Y OF BALTIMORE: (No.

The Taylor Home

FULL NAME

Ella Sutton

(a) RESIDENCE NO.

The Taylor Home

(Usual place of abode)

Length of residence in city or town where death occurred

75 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Caucasian

Single

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Dec. 20 - 1852

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

75

2

14

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore Md

10 NAME OF FATHER

James L. Sutton

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Elizabeth M. Hughes

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Penn

Informant  
(Address)

Miss Grist

2001 Park Ave

1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/4

19 28

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 19, 27, to March 4, 19 28.

that I last saw him alive on March 4, 19 28.

and that death occurred, on the date stated above, at 9:55 m.

The CAUSE OF DEATH\* was as follows:

Myocarditis  
Pulmonary  
Salt bladder disease

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Taylor Home

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

No special test

(Signed)

J. H. Morgan, M. D.

(Address)

6 - E. Glad St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Friends Cemetery

Mar 6 1928

20 UNDERTAKER

ADDRESS

Chas. E. French 802 Madison Ave



31280

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57 E 31280

## PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married, widowed, or divorced

HUSBAND of

(or) WIFE of

DATE OF BIRTH (month, day, and year)

E

Years

Months

Days

If LESS than 1 day. hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant

(Address)

1928

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

3/28/28, 19, to 3/3/28, 19,

that I last saw him alive on 3/4/28, 19,

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH\* was as follows:

Septic Gangrene of Left Foot &amp; Diabetes

(duration)

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

yes Date of 3/3/28

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

J. Winstead, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John F. Denny

715 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

MORE 101 E 31287

# CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1825 C Fayette St., 19-25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Gossman

(a) RESIDENCE NO. 1825 C Fayette St. Ward

(Usual place of abode) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
 How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
-----	-----------------	---

*J* *White* *Married*  
If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Ludrick Gossman*  
DATE OF BIRTH (month, day, year)

DATE OF BIRTH (month, day, and year) Feb 3 1861

AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	67		29	

**OCCUPATION OF DECEASED**

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer

BIRTHPLACE (city or town).....  
(State or country).....

10 NAME OF FATHER *George*

11 BIRTHPLACE OF FATHER (City or town) .....  
(State or country) .....

12 MAIDEN NAME OF MOTHER *21-10*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14 Informant Frank M. Lee  
(Address) 1425 E. 11th St.

15 1920 C. HALSTON JONES, Registrar

# MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 4* 19 *28*

17 HEREDY CERTIFY. That I attended deceased from  
March 28 1928 to March 3 1928

that I last saw her alive on March 3, 1928  
and that death occurred, on the date stated above, at 128

The CAUSE OF DEATH\* was as follows:

Novor Premiuma

CONTRIBUTORY (Secondary) *Acute Cordiae Vileta* (duration) *3* yrs

(duration) yrs. 1 mos. 1 da.

18 Where was disease contracted?

if not at place of death?

Did an operation precede death? ☐ Date of

**Was there an autopsy?**

What test confirmed diagnosis?

3 (Signed) Elaine J. Dawkins M. D.  
64 (Address) 804 N. New

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

March 6<sup>1928</sup>  
ADDRESS

26 UNDERTAKER  
Kindell Duppel - Son 31 Sam W

## HEALTH DEPARTMENT--CITY OF BALTIMORE

1282

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE NO.

(Usual place of abode)

th of residence in city or town where death occurred

75 yrs.

mos.

ds.

How long in U. S. if of foreign birth?

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

YEARS

Months

Days

If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

1928

19

Reg

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1928, to March 4, 1928, that I last saw him alive on March 4, 1928

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis (Cephalic)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? This

(Signed) Shadrach M. M. D.

19 (Address) 1609 Linden Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

1283

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE NO.

(Usual place of abode)

th of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

69 yrs.

3 mos.

17 ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

male White

Widow

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Nov 16-1858

YE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

69

3

17

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work

at home

b) General nature of industry,  
business, or establishment in  
which employed (or employer)

none

c) Name of employer

none

BIRTHPLACE (city or town)  
(State or country)St. Mary's County  
Maryland

10 NAME OF FATHER

Joseph E. Russell

11 BIRTHPLACE OF FATHER (city or town)

St. Mary's Co.

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Laura R. Rock

13 BIRTHPLACE OF MOTHER (city or town)

St. Mary's Co.

(State or country)

Md.

Informant  
(Address)Russell E. Duling  
2505 W. Baltimore City

1928

C. HAMPSON JONES, M. D.

Regist.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/4-1928

17

I HEREBY CERTIFY, That I attended deceased from

2/2nd 1928, to Mar 4 1928

that I last saw him alive on Mar 4 1928

and that death occurred, on the date stated above, at 3:48 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia  
ToxemiaCONTRIBUTORY  
(Secondary)Arterio-sclerosis  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles A. Carson, M. D.

(Address) 2105 N. Balt St

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Washington D. C. Mar 7 1928

20 UNDERTAKER

ADDRESS

Stewart Monro. 108 W. North



31284

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101 E 31284

1-PLACE OF DEATH

Sunderland Hospital

REGISTERED NO.

City of BALTIMORE: (No.

2-FULL NAME

Dina M. Namara

(a) RESIDENCE NO.

1829 W. Pratt

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 11 mos. 10 ds.

St. Ward

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

DATE OF BIRTH (month, day, and year)

March 23 1925

AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

2

11

10

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

J. J. McNamara

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Caroline M. Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

J. J. McNamara 1829 W. Pratt St.

15

1928

H. J. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 5, 1928

19

17

I HEREBY CERTIFY, That I attended deceased from

Feb 22, 1928, to March 5, 1928,

that I last saw her alive on March 5, 1928,

and that death occurred, on the date stated above, at 8:10 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis (Right Ventricle)

CONTRIBUTORY (duration) yrs. mos. ds. (Secondary) Tons. &amp; Pharyngeal Diphtheria

(duration) yrs. mos. ds. 17

18 Where was disease contracted

If not at place of death? - Home

Did an operation precede death? no Data of

Was there an autopsy? no

What test confirmed diagnosis? Culture

(Signed)

19

(Address)

Sunderland Hosp.

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

Date of Burial

March 19 28

20 UNDERTAKER

B. B. W. Spert 1853 W. Balt St

31285

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31285

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. \_\_\_\_\_)

FULL NAME Sarah V. PughRESIDENCE No. 223 S. 7th

(Usual place of abode)

th of residence in city or town where death occurred 71 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

ST. \_\_\_\_\_ WARD \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

male white

5 Single, Married, Widowed, or Divorced, (write the word)

WidowedMarried, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year)

E. Years Months Days If LESS than  
71 \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ 1 day. \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work \_\_\_\_\_b) General nature of industry,  
business, or establishment in  
which employed (or employer) \_\_\_\_\_

c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 29, 1928 to Mar. 3, 1928,  
that I last saw him alive on Mar. 3, 1928and that death occurred, on the date stated above, at 10:45 A. M.  
The CAUSE OF DEATH\* was as follows:Subular pneumonia  
myocarditis, chronic & acute(duration) \_\_\_\_\_ yrs. 2 mos. \_\_\_\_\_ ds.CONTRIBUTORY  
(Secondary) intussusception

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted  
if not at place of death? \_\_\_\_\_Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? General & Sub  
(Signed) C. J. Jones, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

St. Casimir Cemetery 3/6/28  
UNDERTAKER Chas. P. Gaus 118 W. Mt. Royal Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31286

E 31286

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

1928

PR

ARK

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY that I have charge of the

remains described above, held as

(Inquest, autopsy or inquiry.)

I have examined the evidence obtained by said

and that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH was as follows:

Homicide  
Gun shot woundCONTRIBUTORY  
(Secondary)

Signed

18

Address

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

31287

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31287

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD) 5-9

FULL NAME James Jones

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO. 520 W. Eden ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Place of residence in city or town where death occurred

P.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

White Colored ?Married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

?

DATE OF BIRTH (month, day, and year) ? 1878

E

Years

Months

Days

If LESS than  
1 day, hrs  
or min.50

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workSalvageb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Alabama

10 NAME OF FATHER

Amber Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Alabama

12 MAIDEN NAME OF MOTHER

Ellen Hunter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Alabama

Informant

(Address)

Records

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4/1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 12, 1928, to Mar. 4, 1928.that I last saw him alive on Mar. 4, 1928.and that death occurred, on the date stated above, at 12:25 A. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic & acute  
arteriosclerosis  
hypertension(duration) yrs. 3 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA

W. A. Jones, Dec. 6, 1928

20 UNDERTAKER

ADDRESS

James Jones64 Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31288

## CERTIFICATE OF DEATH.

31288

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Argyle Ave. ST. 17-24 WARD)

FULL NAME Ellen Davenport

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1114 Argyle Ave.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)  
Female Negro Widowed.Married, widowed, or divorced  
HUSBAND of  
(or) WIFE of William Davenport.

DATE OF BIRTH (month, day, and year) Aug. 4, 1857

AGE Years Months Days If LESS than 1 day, hrs or min.  
70 6 28

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) Accomac Co. Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Irene Badger

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Accomac Co. Va.Informant Emma Chapman (Daughter)  
(Address) 1406 Madison Ave.

Filed

19

C. HAMPTON JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 2nd 19 28

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24th, 19 28, to March 2nd, 19 28 that I last saw him live on March 1st, 19 28

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH\* was as follows:

Ch. Interstitial Nephritis  
Mitral Ins.

(duration) 1 yrs. 5 mos. 0? ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam  
(Signed) Walter J. Jackson M. D.

19 (Address) 1631 N. Franklin St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

M. Auburn Bur March 6, 1928

20 UNDERTAKER

ADDRESS

Hunt E. E. Co. are

31289

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31289

## CERTIFICATE OF DEATH.

PLACE OF DEATH

University Hospital

OF BALTIMORE: (No.

Lombard &amp; Greene ST

WARD) 30

FULL NAME

Curtis Hayden

RESIDENCE NO.

Essex, Md.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

th of residence in city or town where death occurred

yrs.

mos. 2

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

married, widowed, or divorced

HUSBAND of (or) WIFE of

Mrs. Marie Hayden

DATE OF BIRTH (month, day, and year)

E

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

Electric Crane Operator

b) General nature of industry, business, or establishment in which employed (or employer)

Iron foundry

c) Name of employer

Eastern Rolling Mills

BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Wm. C. Hayden

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Florence Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

Informant (Address)

Hospital Records

1828

C. HAMPSON JONES, M. D.

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-5 1928

17

I HEREBY CERTIFY, That I attended deceased from

3-3 1928 to 3-5 1928

that I last saw him live on

3-5 1928

and that death occurred, on the date stated above, at

5:20 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Lymphatic Leukemia

CONTRIBUTORY (Secondary)

(duration) unknown yrs. mos. ds.

Broncho-pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinician &amp; Laboratory

(Signed)

Henry Vernon Davis, M. D.

3-5, 1928 (Address)

Univ. Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Doraine Cem

DATE OF BURIAL

3/8 1928

20 UNDERTAKER

John G. Connolly

ADDRESS

Essex Md.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31290

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 2038 Robb ST. 9-46 WARD)

FULL NAME Charles Leonard Lewis

RESIDENCE No. 2038 Robb

(Usual place of abode)

Place of residence in city or town where death occurred 31 yrs mos.

ST.

WARD

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

Married, widowed, or divorced

HUSBAND of

or) WIFE of Sadie A Lewis

DATE OF BIRTH (month, day, and year)

E

Years

Months

Days

If LESS than

1 day, hrs

or min.

60

8

18

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) State or country

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

1928

By

C. HAMMOND JONES, Jr. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 11-6, 1927, to 3-4, 1928.

that I last saw him alive on 3-4, 1928, and that death occurred, on the date stated above, at 6:15 P. M.

The CAUSE OF DEATH\* was as follows:

Cirrhosis of Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam (Signed) Wm. J. McKee, M. D.

3-5, 1928 (Address) 1928 in District

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Woodlawn Cemetery Mar 7, 1928 Wm. J. McKee Sons North Sta

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31291

E 31291

## CERTIFICATE OF DEATH.

PLACE OF DEATH

Church Home &amp; Infirmary

Y OF BALTIMORE: (No.

Broadway &amp; Church St. 27-43

FULL NAME

Miss Lelia R. Butler

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO.

316 E. Virginia

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

49 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

White

Single

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

May 23, 1874

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

54 0 11

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Virginia

10 NAME OF FATHER

James R. Butler

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Ficy R. Evans

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Virginia

Informant  
(Address)Elizabeth B. Gambrell  
211 E. Baltimore St.  
Baltimore, Md.

5

1928

G. HANSON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 8, 1928, to Mar. 3, 1928.

that I last saw her alive on Mar 3, 1928.

and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH\* was as follows:

myocardial failure

Peptic ulcer

abdominal adhesions

CONTRIBUTORY (Secondary) Partial obstruction duodenum

myocardial failure (duration) 10 yrs. 3 mos. 3 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? yes Date of Feb. 9, 1928.

Was there an autopsy? no - Mar. 3, 1928

What test confirmed diagnosis?

(Signed) J. Frank Hewitt, M. D.

(Address) Church Home &amp; Infirmary

\*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Burial

Burial

Burial

DATE OF BURIAL

Mar 3, 1928

ADDRESS

Burial



31292

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31292

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE NO.

(Usual place of abode)

th of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male White

Widow

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

TE OF BIRTH (month, day, and year)

E

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

69 70

11

3

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed 1924, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
2-27, 1924, to 3-3, 1924

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Diabetes, Hyperuricemia  
arteriosclerosis  
AtherosclerosisCONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVING

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31293

## CERTIFICATE OF DEATH.

E 31293

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)2-FULL NAME William W. Raver(a) RESIDENCE NO. Pikesville, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. / ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of M. Julia Raver

DATE OF BIRTH (month, day, and year)

July 30, 1885

AGE

Years

Months

Days

4273IF LESS than  
1 day.....hrs.  
or.....min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....Florist(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

Wm. Kier

BIRTHPLACE (city or town).....

(State or country)

Balto. Co. Md.

## 10 NAME OF FATHER

Frederick Raver

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Pa.

## 12 MAIDEN NAME OF MOTHER

Ida Weller

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Balto. Co. Md.

14

Informant  
(Address)Mrs. M. RaverPikesville, Md.

15

Filed

19

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928March 3

17

I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry and that said deceased came to his death  
(autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Poisoned by Carbon Monoxide  
Probably Accident.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)Broncho-pneumonia

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner)

M. D.

3/3, 19 28 (Address)2732 Eastern Ave.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

In the

of death.....yrs.,.....mos.,.....ds.

State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Not buried3/6 1928

20 UNDERTAKER

ADDRESS

Wm. J. Lickens, Son Co. No.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31294

## CERTIFICATE OF DEATH.

129 E 31294

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE NO.

(Usual place of abode)

th of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced, (write the word)

6 married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

7 DATE OF BIRTH (month, day, and year)

E

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 4, 1928, to Mar 5, 1928,  
that I last saw her alive on Mar 5, 1928,  
and that death occurred, on the date stated above, at 5:05 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? to Date of

Was there an autopsy? to

What test confirmed diagnosis?

(Signed) Louis T. Lavy, M. D.

, 19 (Address) W. Balto Gen Hosp

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

3/7 1928

ADDRESS

R 5 - 1928

Per

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31295

## CERTIFICATE OF DEATH.

61-001-  
E 31295

PLACE OF DEATH

OF BALTIMORE: (No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD)

FULL NAME *Servis Miltin or Middleton*RESIDENCE No. *831 W. Lexington* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

How long in U. S., if of foreign birth? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*Married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) \_\_\_\_\_

Years Months Days If LESS than 1 day, hrs. or min. *29*

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work *Salvage*b) General nature of industry, business, or establishment in which employed (or employer) *Sead Grading*

c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town)

State or country *South Carolina*10 NAME OF FATHER *Servis Miltin*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *South Carolina*12 MAIDEN NAME OF MOTHER *Mary*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *South Carolina*

Informant

(Address) *Records*

Filed

1928

C. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/4/1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 29, 1928* to *Mar. 4, 1928*that I last saw him live on *Mar. 4, 1928*and that death occurred, on the date stated above, at *2:00 P. M.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia - Chronic**Sead encephalopathy*(duration) yrs. mos. ds. *10*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *yes*What test confirmed diagnosis? *General & Sead*(Signed) *G. J. Williams, M. D.*

, 19 (Address) \_\_\_\_\_

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*M. J. Formick & Co.**3-7 1928*

UNDERTAKER

ADDRESS

*Jas. W. Skinned 1620 E. Mad at*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31296

## CERTIFICATE OF DEATH.

E 31296

PLACE OF DEATH

OF BALTIMORE: (No. *Senar Hospital* ST. *359* WARD)FULL NAME *Sarah Lichtenberg*RESIDENCE No. *2224 Madison Ave* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE \_\_\_\_\_ 5 Single, Married, Widowed, or Divorced, (write the word)

*married*

Married, widowed, or divorced

HUSBAND of \_\_\_\_\_

or WIFE of \_\_\_\_\_

*Dr M. L. Lichtenberg*DATE OF BIRTH (month, day, and year) *Dec 25 1897*Years Months Days If LESS than 1 day, hrs. or min.  
*30 2 9 10*

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work *Housewife*

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) *Baltimore Md*  
(State or country)10 NAME OF FATHER *Abraham Sogner*11 BIRTHPLACE OF FATHER (city or town) *Russia*  
(State or country)12 MAIDEN NAME OF MOTHER *Jennie*13 BIRTHPLACE OF MOTHER (city or town) *Russia*  
(State or country)Informant *Robt Dehursky*  
(Address) *Lakeview Ave*Filed *1928* *HAMPSON JONES, M. D.* Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/5/1928*

17

I HEREBY CERTIFY, That I attended deceased from

*2/5/1928*, to *3/5/1928*that I last saw her alive on *3/5/1928*and that death occurred, on the date stated above, at *2,300 a.m.*

The CAUSE OF DEATH\* was as follows:

*Staphylococcus meningitis*(duration) yrs. mos. ds. *2*CONTRIBUTORY *Bilateral mastoiditis*  
(Secondary) *sinus thrombosis*(duration) yrs. mos. ds. *8*18 Where was disease contracted  
if not at place of death?Did an operation precede death? *Yes* Date of *2/28/28*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *John A. Asker* M. D., 19 *Senar Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Baltimore Cemetery**3/6 1928*

20 UNDERTAKER

ADDRESS

*John Lewis 1439 E. Baltimore*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31297

## CERTIFICATE OF DEATH.

90 E 31297

PLACE OF DEATH

OF BALTIMORE (No. 9 E, Belvidere Ave. 127-53 ST. WARD)

FULL NAME Annis E. Oldham

RESIDENCE NO. 9 E, Belvidere Ave. ST. WARD

(Usual place of abode)

Date of residence in city or town where death occurred

27 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White

Widow

(or) WIFE of

HUSBAND of Spencer J. Oldham

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

7

9

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

England Ely north

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

Elizabeth Dunkerton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

Informant (Address)

Spencer J. Oldham 9 E, Belvidere Ave.

Filed

1928

R. J. Jones, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 13 1928 to March 3 1928.

that I last saw her alive on March 3 1928.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Cerebral arteriosclerosis as chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? h Date of

Was there an autopsy? m

What test confirmed diagnosis? Exam.

(Signed) W. Marshall, M. D.

3, 1928 (Address)

3429 Chestnut St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Spring Ridge

Mar 6 1928

20 UNDERTAKER

ADDRESS

W. Marshall 3539 Fall Rd

31298

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE 65 Years 62 Month 7 Days 24 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant

(Address)

Filed

19

JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar - 19 28

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 19 28, to Mar - 4, 19 28, that I last saw him alive on Mar. 4, 19 28, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Tumor of (benign) spine  
Spinal Cord  
(operation) - Spinal  
Anesthesia (duration) 8 yrs. 9 mos. 0 ds.CONTRIBUTORY  
(Secondary)

(duration) 0 yrs. 1 mos. 0 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of July 19 27

Was there an autopsy? No

What test confirmed diagnosis? Plain x-ray  
(Signed) R. A. Warner, M. D.

19 (Address) 907 H. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Ashbury Ave.  
Carroll Co Md

20 UNDERTAKER

Robert Brooks &amp; Son

DATE OF BURIAL

3/7 1928

ADDRESS

Cathlam  
Hollins

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31299

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. *801 N. Street* ST. *7-11* WARD)FULL NAME *Henri Wade*RESIDENCE No. *801 N. Street*

(Usual place of abode)

Age of residence in city or town where death occurred *57* yrs. mos.

ds.

How long in U. S., if of foreign birth?

90 E 31299

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

Married, widowed, or divorced

HUSBAND of

or WIFE of

*Louise Lowensen*

DATE OF BIRTH (month, day, and year)

*July 11-1870*

E

Years

Months

Days

*57**7**21*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

*Carpenter*

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) State or country

*Baltimore*

NAME OF FATHER

*Thomas Wade*

BIRTHPLACE OF FATHER (city or town) (State or country)

*Ida Stalling*

MAIDEN NAME OF MOTHER

*Elizabeth Stalling*

BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ida*

Informant (Address)

*Mrs. Louise Wade  
801 N. Street*

Filed

1920

JAMES H. JOY, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 2 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 2 1928*that I last saw him alive on *March 2 1928*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Acute Myocardial  
Pericarditis*

CONTRIBUTORY (Secondary)

*Pneumo-pneumonia*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *James H. Joy*, M. D., 19 (Address) *30 E. Preston St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

*Parkwood Cem*

UNDERTAKER

*John Ulrich*

DATE OF BURIAL

*Mar 8 1928*

ADDRESS

*2908 Orleans St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31300

## CERTIFICATE OF DEATH.

113 ✓ E 31300

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3803 E Lombard St. 96-37 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 3803 E Lombard St. \_\_\_\_\_ Ward \_\_\_\_\_

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 Filed

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19

19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Subacute Rickets

CONTRIBUTORY

(Secondary)

Mat. 9/10/27 (Signed) W. C. Stades M. D.19 (Address) 1438 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

1301

## CERTIFICATE OF DEATH.

17 E 31301

## PLACE OF DEATH

OF BALTIMORE: (No. *Hebrew Home for the Aged* ST., *40* WARD)FULL NAME *Solomon Goldman*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE No. *2100 E Baltimore St* ST., *40* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Age of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? *40* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

married, widowed, or divorced

HUSBAND of *Dora Goldman* or) WIFE ofDATE OF BIRTH (month, day, and year) *March 10, 1887*E. Years *107* Months *—* Days *—* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town, State or country) *Russia*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town, State or country) *Russia*12 MAIDEN NAME OF MOTHER *Russia*13 BIRTHPLACE OF MOTHER (city or town, State or country) *Unknown*Informant (Address) *Jack Lewis 1439 E Baltimore St*

Filed

C. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/5* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *Jan*, 19*27*, to *March 5*, 19*28*.that I last saw him alive on *March 5*, 19*28*.and that death occurred, on the date stated above, at *1:30 p* m.

The CAUSE OF DEATH\* was as follows:

*d. nephritis*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) *15* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Lucy Whitehouse*, M. D., 19 (Address) *1810 E Baltimore St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebrew Mt Carmel**3/6* 19 *28*

UNDERTAKER

ADDRESS

*Jack Lewis 1439 E Baltimore St*

6-1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31302

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1407- Bentlow* ST., *15-68* WARD) *129*2. FULL NAME *Alvin E. Worley*REGISTERED NO. *E 31302*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *1407- Bentlow* ST., *15-68* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE *Male white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

6 married, widowed, or divorced

HUSBAND of

*Georgia Goye*DATE OF BIRTH (month, day, and year) *5/13/1877*AGE *50* Years *9* Months *19* Days *1* day, *1* hrs. *1* min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Interior Painter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Balto. Ind.*  
(State or country)10 NAME OF FATHER *David Worley*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Balto. Co. Ind.*12 MAIDEN NAME OF MOTHER *Flora Dodge*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Mass.*Informant *Mrs. Georgia Worley*(Address) *1407- Bentlow St.*Filed *1928*Registrar *George J. Ryth*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-4-1928*

17

I HEREBY CERTIFY, That I attended deceased from

*2-25-1928* to *3-4-1928*that I last saw him alive on *3-3-1928*and that death occurred, on the date stated above, at *3:00 P. M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*(duration) *?* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Ch. Hypertension*(duration) *?* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical Findings*(Signed) *George J. Ryth* M. D., 19 (Address) *4000 Edmonson Dr*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Landon Park Cem.*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*George J. Ryth 1750 Harbor St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31303

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 644 Portland

ST. 27-30 WARD

FULL NAME VIRGIN GROCHIK

RESIDENCE NO. 644 Portland

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

th of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

1 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)  
Singlemarried, widowed, or divorced  
HUSBAND of  
(or) WIFE of

TE OF BIRTH (month, day, and year)

July 4, 1927

E - Years

8 Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore Md.

10 NAME OF FATHER

Mik. Grochik

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Lithuania

12 MAIDEN NAME OF MOTHER

Mary Sevandoska

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Lithuania

Informant

V. Grochik

(Address)

644 Portland Street

Filed

1928

MAY 1928

Register

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 4, 1928

17

HEREBY CERTIFY, That I attended deceased from  
March 1, 1928, March 4, 1928  
that I last saw her alive on March 4, 1928  
and that death occurred, on the date stated above, at 9:30 PM  
The CAUSE OF DEATH was as follows:

Bronche Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. B. Trilinger, M.D.

3.5.1928

(Address) 682 W. 11th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Holy Redeemer Cw.

March 7, 1928

20 UNDERTAKER

John A. Griebauckas Jr

ADDRESS

423 S. Paca St.

31304

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31304

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 128 N. Durham

St. 6-9 Ward)

## 2-FULL NAME

Mary Griffith

(a) RESIDENCE NO. 128 N. Durham

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? 22 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male  
 4 Color or Race white  
 5 Single, Married, Widowed, or Divorced. (write the word) married

If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

Daniel G. Griffith

DATE OF BIRTH (month, day, and year)

Mar 2/1874

AGE Years Months Days IF LESS than  
 54 0 1 1 day.....hrs.  
 or.....min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

Wales

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Wales

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Wales

14

Informant  
(Address)Gertrude Fennel  
Wilkes-Barre, Pa

15

Filed..... 19

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 2/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
 (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry  
 (Inquest, autopsy or inquiry.)

inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidental Ill. Gas Asphixiation.

(Leaky Hose)

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(duration) yrs. mos. ds.

(Coroner)

(Address)

3/5/28

500 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Oak Lawn Cemetery Mar 6/28

20 UNDERTAKER

ADDRESS

Mrs C. Fuller 2334 Jefferson

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31305

## CERTIFICATE OF DEATH.

38 E 31305  
REGISTERED NO.(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.,

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 29, 1928, to March 2, 1928.

that I last saw him alive on March 2, 1928

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isidor I. Levy, M. D.

Mar. 1928 (Address) 2324 Eastern Place

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31306

## CERTIFICATE OF DEATH.

87E 31306

## PLACE OF DEATH

OF BALTIMORE: (No. 1439 N. Carey ST., 15-23 WARD)

## FULL NAME

RESIDENCE No. 1439 N. Carey ST., WARD

(Usual place of abode)

Date of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single Married, Widowed, or Divorced, (write the word)

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

1928

JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3, 3

1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 17<sup>th</sup>, 1928, to Feb 8<sup>th</sup>, 1928, that I last saw him alive on Feb 2<sup>nd</sup>, 1928

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia &amp; Bronchitis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Based on World War

18 Where was disease contracted

If not at place of death? In France

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By X-ray

(Signed)

M. D.

315 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

5 6 1928

20 UNDERTAKER

ADDRESS



31307

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Prudent Hospital

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Sarah Satterfield

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

727 Sterling

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

F

Colored

Single

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

March 4, 1894

AGE

33

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

34

march

29

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

M.D.

10 NAME OF FATHER

John Satterfield

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Isabella Griffin

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

M.D.

Informant  
(Address)Isabella Satterfield  
727 Sterling St.

Filed

1928

C-19

H. J. JOHNS, M. D.

Registar

Registar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-3

19 18

17

I HEREBY CERTIFY, That I attended deceased from

3-1, 19 28, to 3-3, 19 28

that I last saw him alive on

3-3, 19 28

and that death occurred, on the date stated above, at

9 a. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration)

yrs.

mos.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

yes

Date of

3/1/28

Was there an autopsy?

no

What test confirmed diagnosis?

clinical

(Signed)

W. B. Butler

M. D.

19

(Address)

420 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Asbury Cemetery

DATE OF BURIAL

march 7, 19 28

20 UNDERTAKER

Edward Bryan

ADDRESS

4601 Orleans St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31308

## CERTIFICATE OF DEATH.

58E 31308

-PLACE OF DEATH

-OF BALTIMORE: (No. *Baltimore City Hospital 5-8* ST. WARD)-FULL NAME *Ilda Frasier*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

a) RESIDENCE NO. *1212 Orleans*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

*Life* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male colored**married*

married, widowed, or divorced

WIFE of

*Richard Frasier*

DATE OF BIRTH (month, day, and year)

*1878*

YE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*50*

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

*Housewife*

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*unknown*

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*unknown*Informant  
(Address)*Hospital Records*

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 3 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Feb. 24*, 1928, to *March 3rd*, 1928,  
that I last saw her alive on *March 3rd*, 1928  
and that death occurred, on the date stated above, at *6-9* m.

The CAUSE OF DEATH\* was as follows:

*Pernicious anemia*

(duration)

*unknown*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

*unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*

What test confirmed diagnosis?

*Clinical, Lab + Path*

(Signed)

*L. E. Madden*, M. D.

19

(Address)

*Baltimore City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Asbury cemetery**March 28*

20 UNDERTAKER

ADDRESS

*Edward Bryon Orleans 1st*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31309

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

419 N. Stricker St.

ST.

WARD)

## 2-FULL NAME

Annie E. Robinson

REGISTERED 31309

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

419 N. Stricker St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

F.

Negro

Married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Thos. E. Robinson

DATE OF BIRTH (month, day, and year)

Nov. 25th. 1877

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

50

3.

9

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER Dennis Barnett

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md

12 MAIDEN NAME OF MOTHER Alice Corsey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

Chestertown.

Informant  
(Address)Thos. Robinson  
419 N. Mount St.

Filed

D

1928: J. J. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4'28 19

17

I HEREBY CERTIFY, That I attended deceased from  
March 3rd, 1928, to March 4th, 1928.

that I last saw him alive on March 4th, 1928,

and that death occurred, on the date stated above, at

7:30 a.m.

The CAUSE OF DEATH\* was as follows:

Acct. Dilatation of heart

(duration)

yrs.

mos

1 ds.

CONTRIBUTORY  
(Secondary)

Aortic Ins.

(duration)

1 yrs. ?

mos.

? ds.

18 Where was disease contracted

if not at place of death?

At place of death

Did an operation precede death? NO. Date of

Was there an autopsy? NO.

What test confirmed diagnosis? Physical Exam.

(Signed)

Walter J. Jackson

M. D.

, 19 (Address) 1631 W. Franklin St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL  
Mt Zion Cem

Mch 7th 1928

20 UNDERTAKER

ADDRESS

A. Jones

111 S. Gilman

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31310

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. of Baltimore)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from Mar 2, 1928, to Mar 3, 1928, that I last saw him alive on Mar 3, 1928, and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration)

yrs.

mos.

2 ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam

(Signed)

3/3/28

Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

## UNDERTAKER

ADDRESS

MAR 6 - 1928

JONES, M. Registrar

Ba Jones

111 S. L. Jones

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31311

## CERTIFICATE OF DEATH.

E 31311

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1126 W. M. Murre St., 16-22 Ward)2-FULL NAME Mather (Mary R.) Gosnell. Ric Bailey(a) RESIDENCE NO. 1126 W. M. Murre St., \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) WidowedIf married, widowed, or divorced HUSBAND of (or) WIFE of Wm H GosnellDATE OF BIRTH (month, day, and year) 7 21 1874AGE Years 53 Months 7 Days 11 IF LESS than 1 day.....hrs. or.....min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) \_\_\_\_\_

(State or country) Granite Md.10 NAME OF FATHER J W. Bailey

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_

(State or country) Granite Md.12 MAIDEN NAME OF MOTHER Amanda A Davis

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_

(State or country) Granietown Md14 Informant Amanda A Bailey  
(Address) 1126 W. M. Murre St15 Filed 1928 H. J. Jones, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Bladder  
(duration) 3 mos. 3 ds.CONTRIBUTORY (Secondary) Rh AustinMar 28 (Signed) 976 Bladys M. D.  
(Coroner)4219 (Address) 143 W. Bay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Granite Md 3 16 1928

20 UNDERTAKER ADDRESS

George J. Ruth 1735 Harford Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31312

## CERTIFICATE OF DEATH.

31312

PLACE OF DEATH

OF BALTIMORE (No. 707 Carroll Ave ST. 13-52 WARD)

FULL NAME Joseph O. Harris

RESIDENCE NO. 707 Carroll Ave ST. WARD

(Usual place of abode)

Date of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Informant

(Address)

File

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 29, 1928, to March 4, 1928

that I last saw him alive on March 4, 1928

and that death occurred, on the date stated above, at 1980 m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

Signed: W. E. Kelly, M. D.

(Address) 4140 Somerset Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOMAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

31313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 31313

1-PLACE OF DEATH

City of BALTIMORE: (No. 1223 E. Chase

St. 10<sup>th</sup> Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barrie Miller

(a) RESIDENCE NO. 1223 E. Chase

St. 10<sup>th</sup> Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. da.

How long in U. S. if of foreign birth 7 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of John B. Miller

DATE OF BIRTH (month, day, and year) Nov 18

AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.. 69 - -

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md  
(State or country)

10 NAME OF FATHER John Kimmmerlein

11 BIRTHPLACE OF FATHER (City or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Louise Haas

13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)

14 Informant Mrs. Andrew G. Miller  
(Address) 2614 E. Hoffman St.

15 Filed 1928 10 10 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 28

March 6

17 I HEREBY CERTIFY, That I attended deceased from 12/8, 1927, to 3/6, 1928.

that I last saw him alive on 3/5, 1928.

and that death occurred, on the date stated above, at 12:25 A.M.

The CAUSE OF DEATH\* was as follows:

Percussion of gall bladder  
Unknown (duration) yrs. mos. da.

CONTRIBUTORY Intestines & liver  
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. A. B. Smith, M. D.

3/6, 1928 (Address) 914 E. Broadway

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery March 8 1928

20 UNDERTAKER

ADDRESS

Henry Street Lin 1301 E. Eng 118

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31314

## CERTIFICATE OF DEATH.

E 31314

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Poultney St.

ST. 23-33 WARD

## 2-FULL NAME

Frederick W. Schleich

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

14 Poultney St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

56

yrs.

4

mos.

14

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male.

White.

Married.

If married, widowed, or divorced

HUSBAND of

WIFE of

Margaret Schleich.

DATE OF BIRTH (month, day, and year) Oct. 19, 1871

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

56

4

14

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Conrad Schleich.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Henrietta Bausman.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany.

Informant

Margaret Schleich. (wife)

(Address)

14 Poultney St.

Filed

C. HAMMON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1928

17

I HEREBY CERTIFY, That I attended deceased from

January 1, 1924, to March 4, 1928.

that I last saw him alive on March 3, 1928.

and that death occurred, on the date stated above, at 3.25 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test (clinical diagnosis)

Clinical Diagnosis

(Signed)

Oto M. Reinhardt, M. D.

2/6, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Holy Redeemer

3-7 1928

UNDERTAKER

ADDRESS

2813 Ave 115 &amp; West St

31315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 31315

1-PLACE OF DEATH

City of BALTIMORE: (No. 120 N Elwood Ave 6-11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Angelini

(a) RESIDENCE NO. 120 N Elwood Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) —

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) July 24 1926

AGE Years 1 Months 7 Days 29 IF LESS than 1 day...hrs. or...min..

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —  
(b) General nature of industry, business, or establishment in which employed (or employer) —  
(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Dominick

11 BIRTHPLACE OF FATHER (City or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Trombetta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Dominick Angelini (Address) 120 N Elwood Ave

15 Filed 1928 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1928 19

17 I HEREBY CERTIFY, That I attended deceased from March 4 1928 to March 5 1928, that I last saw him alive on March 5 1928, and that death occurred, on the date stated above, at 3:41 a.m.

The CAUSE OF DEATH\* was as follows: Brachio-Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert Scagnetti, M. D.

(Address) 244 S Epton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent

Date of Burial

20 UNDERTAKER

ADDRESS

Wendell Klippel, Jr March 1928 3/ Sam



31316

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31316

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

712 S. Green

WARD 31

## 2-FULL NAME

Lucinda Turner

(a) RESIDENCE NO.

712 S. Green

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

3

yrs.

—

mos.

—

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

John Turner

DATE OF BIRTH (month, day, and year)

1886

AGE

Years

Months

Days

42

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer)

@ home

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Rocky Mount,

N. Carolina

10 NAME OF FATHER

Watson P. H.

11 BIRTHPLACE OF FATHER (city or town)

Rocky Mount,

(State or country)

N. Carolina

12 MAIDEN NAME OF MOTHER

Emma Hensel

13 BIRTHPLACE OF MOTHER (city or town)

Rocky Mount,

(State or country)

N. Carolina

Informant (Address)

John Turner

712 S. Green

1928

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/3 1928

17

I HEREBY CERTIFY, That I attended deceased from

2/25 1928 to 3/3 1928

that I last saw her alive on

3/2 1928

and that death occurred, on the date stated above, at

12 H.

The CAUSE OF DEATH\* was as follows:

Pulmonary Intercesses

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

"Johns Hopkins"

(Signed)

Dan J. Anderson, M. D.

(Address)

122 W. Lee St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, Homicidal. See reverse side for additional space.

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

UNDERTAKER

ADDRESS

Virginia A. Brooks 1468 N. Carey



1317

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. **E 31317**  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

PLACE OF DEATH *University Hospital*OF BALTIMORE: (No. *Lombard & Greene*)FULL NAME *William J. Hunt*RESIDENCE NO. *211 S. Gilman*  
(Usual place of abode)Length of residence in city or town where death occurred *42* yrs.

ST. \_\_\_\_\_ WARD \_\_\_\_\_

How long in U. S., if of foreign birth? (If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Male* *White**Married*

married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Mrs Jennie Hunt*DATE OF BIRTH (month, day, and year) *Jan 23, 1860*

E

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*11**13*

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work*Elevator operator*b) General nature of industry,  
business, or establishment in  
which employed (or employer)*Glass work.*

c) Name of employee

*Pittsburg Plate Glass Co.*BIRTHPLACE (city or town)  
(State or country)*Virginia*

10 NAME OF FATHER

*Amos Hunt*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Va.*

12 MAIDEN NAME OF MOTHER

*Mary Verto*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Va.*Informant  
(Address)*Hospital Records*

Filed

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-6-1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*2-17-1928*, to *3-6-1928*,  
that I last saw him alive on *3-5-1928*and that death occurred, on the date stated above, at *12<sup>20</sup> a.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of the pylorus of the  
stomach with perforation and  
general peritonitis.*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)(duration) *instantaneous*18 Where was disease contracted  
if not at place of death?*unknown*

Did an operation precede death?

*no* Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Clinical & X-ray*

(Signed)

*Henry Vincent Davis* M. D.

3/6 1928 (Address)

*Univ. Hosp.*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Landon Park**3/7/28*

20 UNDERTAKER

ADDRESS

*Harry Witzke**1531 W. Lombard St*

31318

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31318

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Milton M. Leland* ST. *25-73* WARD)2-FULL NAME *Anna M. Berner*(a) RESIDENCE NO. *Milton Ave. Leland* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*If married, widowed, or divorced HUSBAND of (or) WIFE of *Daughter*DATE OF BIRTH (month, day, and year) *Feb 21, 1911*AGE Years Months Days If LESS than 1 day, hrs. or min. *17 1 12*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Balto Md*10 NAME OF FATHER *Gustav G. Berner*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md*12 MAIDEN NAME OF MOTHER *Margaret Welch*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *England*Informant (Address) *Mrs Margaret Welch*

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 3 1928*

17

I HEREBY CERTIFY That I attended deceased from *July 25 - 1928* to *Mar. 3 1928*that I last saw him alive on *3/3/28* and that death occurred, on the date stated above, at *7:35 p.m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis*

CONTRIBUTORY (Secondary)

(duration) *2* yrs. *6* mos. *6* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

19

(Address) *1340 St Charles*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral**Mar 7 1928*

20 UNDERTAKER

ADDRESS

*Chas. H. Spence**1501 E. Fort E*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31319

31319

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 Etting ST., 14-20 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 1702 Etting ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

Colored

Single

If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

1

6

23

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)Virginia Hayme  
1702 Etting St.  
C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 6 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 1 1928 to Mar 6 1928

that I last saw her alive on Mar 5 1928

and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia  
(Primary)

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Fry, M. D.  
36, 1928 (Address) 1928 Pa Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Auburn

3/6 1928

ADDRESS

20 UNDERTAKER

Mrs. Geo. H. Holland 1831 Druid Hill

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31320

## CERTIFICATE OF DEATH.

E 31320

PLACE OF DEATH

OF BALTIMORE: (No. 1215 S. Carey

ST. 16-23 WARD)

FULL NAME

Geraldine V. Guidley

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO.

1215 S. Carey

ST. WARD

(Usual place of abode)

th of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male White

Single

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

TE OF BIRTH (month, day, and year)

Sept 6, 1926

SE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

1

5

27

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work

None

b) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Balt. Md.

NAME OF FATHER

Wm. Holmes Guidley

BIRTHPLACE OF FATHER (city or town)  
(State or country)

N. C.

MAIDEN NAME OF MOTHER

Virginia A. Richter

BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Balt. Md.

Informant  
(Address)Wm. H. Guidley  
1215 S. Carey St.

6-1926

HAMPSON JONES, Jr.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 4 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr 20, 1928, to Mar 4, 1928

that I last saw him on Mar 4, 1928

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia  
(Primary)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signed) W. H. Campbell, M.D.

5, 1928 (Address) 1644 Hancock

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

London Park

DATE OF BURIAL

Mar 7, 1928

UNDERTAKER

Mrs. John W. Templeton 801 Br. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

31321

CERTIFICATE OF DEATH.

117 E 31321

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 4-76 Ward)

2-FULL NAME Anna S. Denson

(a) RESIDENCE NO. 717 West Fayette St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of John Denson

DATE OF BIRTH (month, day, and year) May 21 - 1875

AGE Years 52 Months 9 Days 13 IF LESS than 1 day.....hrs. or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) Germany

10 NAME OF FATHER Frederick Ditz

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Shtrost

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) Germany

14 Informant Mrs. Clara P. Pack (Address) 1717 - 1st St. S. Baltimore

1928 C. H. Harpoy Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute appendicitis

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.

CONTRIBUTORY Peritonitis (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Signed) Reginald J. Allen M. D. (Coroner)

3/4, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cemetery Date of Burial 3/7 1928

20 UNDERTAKER Williams Cook ADDRESS SOLE Natch



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31322

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married, widowed, or divorced

HUSBAND of  
or) WIFE of

DATE OF BIRTH (month, day, and year)

E

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
State or country

NAME OF FATHER

BIRTHPLACE OF FATHER (city or town)  
(State or country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

19

HAMPSON JONES, Jr.  
Register

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 19 26 to March 4, 19 28.

that I last saw her alive on March 4, 19 28

and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Breast

(duration) 10 yrs. - mos. - ds.

CONTRIBUTORY  
(Secondary)

(duration) - yrs. 6 mos. - ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? - Date of -

Was there an autopsy? No

What test confirmed diagnosis? Lab. Exam

(Signed)

Richard E. Coleman, M. D.

19

(Address)

Latrobe apt. City

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Melian Cook

502 E 11th

31323

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH 3224 Elgin Ave

OF BALTIMORE: (No. 4

ST. 15-61 WARD)

FULL NAME

Charles E. Lemis

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO.

3224 Elgin Ave

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white married

HUSBAND of (or) WIFE of

Laura T. Lemis

DATE OF BIRTH (month, day, and year)

April 1876

AGE

52

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

Advertiser

b) General nature of industry, business, or establishment in which employed (or employer)

T.O.

c) Name of employer

BIRTHPLACE (city or town) (State or country)

Boston Mass

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

unknown

Informant

(Address)

Laura T. Lemis

3224 Elgin Ave

Filed

1928 19

G. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 5 1928

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1928 to March 5, 1928.

that I last saw him alive on March 5, 1928,

and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed)

J. A. Zerler M. D.

35, 1928 (Address)

Medical Arts Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Probalan Cemetery

Mar 5 1928

UNDERTAKER

ADDRESS

Wm. G. Goff 502 E. North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31324

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31324

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7-9 Ward)2-FULL NAME Anna R. Albert(a) RESIDENCE NO. 506 N. Broadway

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female

White

single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Feb 11/1842

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

86

0

23 24

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

At home

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

10 NAME OF FATHER

Agustus J. Albert

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER Frances Taylor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant Hospital Records

(Address)

15 1928

C. HAMMOND JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5/2817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
inquiry find that said deceased came to her death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Intracranial Hemorrhage- Accidental  
fell down stairs at her home

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

M. D.

3/5/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds.

In the

State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL

20 UNDERTAKER

ADDRESS

31325

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 313251-PLACE OF DEATH Pronounced dead at the  
City of BALTIMORE: (No. South Baltimore General Hospital 24-34 Ward)2-FULL NAME Patrick E. DeYoung.(a) RESIDENCE NO. 1715 Light St.(Usual place of abode) Unknown St.        Ward         
Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Married.If married, ~~Widowed or Divorced~~  
HUSBAND of Annie J. DeYoung.  
(Or) WIFE ofDATE OF BIRTH (month, day, and year) August 10, 1882AGE Years Months Days 45 6 24 IF LESS than 1 day.....hrs. or.....min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Pile driver.(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

BIRTHPLACE (city or town) Canada.

(State or country)

10 NAME OF FATHER Edward DeYoung.11 BIRTHPLACE OF FATHER (city or town) Canada.

(State or country)

12 MAIDEN NAME OF MOTHER Marion13 BIRTHPLACE OF MOTHER (city or town) Canada.

(State or country)

14 Informant Annie J. DeYoung, (wife)  
(Address) 1715 Light St.15 1926 C. HAMPSON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to his death  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)        M. D.  
(Coroner)1/6, 1928 (Address) 1017 E. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Saintfield, March 5, 1928.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial 3/7 192820 UNDERTAKER J. J. BaileyADDRESS 1318 Light St

31326

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31328

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 1271 Washington Blvd. ST. 117 WARD)

## FULL NAME

Charles J. Sebours

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO. 1271 Washington Blvd. ST. 117 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widowed

married, widowed, or divorced

HUSBAND of

(or) WIFE of

Margaret J. Sebours

DATE OF BIRTH (month, day, and year)

July 10, 1863

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

## OCCUPATION OF DECEASED

(a) Trade profession or particular kind of work

Labor Brickyard

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Md. John Sebours

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

France

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

France

Informant

(Address)

M. J. Sebours, Jr. 1271 Washington Blvd.

Filed

1928

19

HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1928

17

I HEREBY CERTIFY, That I attended deceased from Oct. 1927 to Mar 6 1928

that I last saw him alive on March 5 1928

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH\* was as follows:

Acute appendicitis

Appendiceal abscess

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) yrs. 5 mos. ds.

(duration) yrs. mos. ds. 4

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct. 24, 1927

Was there an autopsy? no Jan. 6, 1928

What test confirmed diagnosis? Operation

(Signed) Dr. Buchner, M. D.

3/6, 1928 (Address) 37 S. Street St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Audon Fort Lee, N. J. Mar 9 1928

UNDERTAKER

ADDRESS

John J. Cowan &amp; Son 901, 903



HEALTH DEPARTMENT—CITY OF BALTIMORE

31327

CERTIFICATE OF DEATH.

E 31327

1-PLACE OF DEATH

City of BALTIMORE: (No. 417 Eversham Ave St. 27 Ward 8)

2-FULL NAME

(a) RESIDENCE NO. 417 Eversham St. 27 Ward 8

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White infant

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Nov 19 1927

AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

5-3

16

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15 Filed

1928

C. HAMMOND JONES, M. D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-6-1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1928, to Mar. 6, 1928, that I last saw him alive on Mar. 5, 1928, and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia (R.) Side

(duration) .....yrs. ....mos. ....ds. 9 mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinician

(Signed)

H. C. Hoers.

M. D.

3-6-1928 (Address) 5600 York Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

St Mary Cemetery March 19 28  
Mary M. Medley 501 E 33 St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31328

## CERTIFICATE OF DEATH.

E 31328

-PLACE OF DEATH

OF BALTIMORE: (No.

-FULL NAME

a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male white

married

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Thomas H Wiley

DATE OF BIRTH (month, day, and year)

Oct 21 1858

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

69

4

13

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

housewife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Janettsville  
Howard co md

10 NAME OF FATHER

Henry B Wheeler

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Howard co md

12 MAIDEN NAME OF MOTHER

Mary Ann Carter

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Howard co md

Informant  
(Address)Mary Wiley Sloan  
1520 Woodward Ave

Filed - 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 6 1928

17

I HEREBY CERTIFY, That I attended deceased from  
March 7, 1928, to March 6, 1928,that I last saw her alive on March 6, 1928,  
and that death occurred, on the date stated above, at 11:40 p. m.

The CAUSE OF DEATH\* was as follows:

Exophthalmic Goiter

(duration)

yrs.

1 mos

ds.

CONTRIBUTORY  
(Secondary)

Broncho-Pneumonia

(duration)

yrs.

2 mos.

ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical Evidence

(Signed)

J. H. Lusk

M. D.

(Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVES

Bethel Cemetery

UNDERTAKER

E. H. Sloan

DATE OF BURIAL

March 9 1928

ADDRESS

Janettsville  
md

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31329

## CERTIFICATE OF DEATH

E 31329  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Bryant Genl Hospital* Ward)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Widowed

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## DATE OF BIRTH (month, day, and year)

10-29-1881

## AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min..

46

4

8

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 File

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

3-7-28

17

I HEREBY CERTIFY, That I attended deceased from

1-26-28, 19, to 3-7-28, 19,

that I last saw him alive on 3-7-28, 19,

and that death occurred, on the date stated above, at 140 A. M.

The CAUSE OF DEATH\* was as follows:

Cholelithiasis - Carcinoma Uterus

## CONTRIBUTORY

(Secondary)

(duration) 14 yrs. mos. da.

(duration) 5 yrs. mos. da.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of 2-23-28

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**E 31330**

1-PLACE OF DEATH

City of BALTIMORE: (No. 1034 Druid Hill St. 17-24 Ward)

2-FULL NAME Earl Wright

(a) RESIDENCE NO. 1034 Druid Hill

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

C

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

May 17 1927

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

9 17 19

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country)

10 NAME OF FATHER Eddie Wright

11 BIRTHPLACE OF FATHER (city or town) Ry  
(State or country)

12 MAIDEN NAME OF MOTHER Murvin

13 BIRTHPLACE OF MOTHER (city or town) Savannah  
(State or country)

14 Informant Ellen Murvin  
(Address) 1034 Druid Hill

15 Filed 1928 HARRISON JONES, M. D.  
Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

**E 31330**

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 6 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 5 1928, to March 6 1928,

that I last saw him alive on March 6 1928,

and that death occurred, on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH was as follows:

Bronchitis Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY Acute Bronchitis  
(Secondary)

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Jones, M. D.

3/6, 1928 (Address) 1126 Druid Hill

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Auburn Cem Date of Burial March 7, 1928

20 UNDERTAKER Samuel Easton ADDRESS 916



E 31331 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31331

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home Infirmary* ST. *679* WARD)

## 2-FULL NAME

*Mr. Newton Wastler*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*Towson Md*

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*70* yrs.

mos.

*21* ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Mallie Wastler*

DATE OF BIRTH (month, day, and year)

*Sept 16, 1858*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*69**6**20*

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Tommy Goddard*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

*Self*BIRTHPLACE (city or town)  
(State or country)*Md*

## 10 NAME OF FATHER

*Henry Wastler*

## 11 BIRTHPLACE OF FATHER

*Md*

(State or country)

## 12 MAIDEN NAME OF MOTHER

*Sarah Donsing*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Md*Informant  
(Address)*Home Wastler  
Towson Md*

Filed

*HAMPTON JONES, H. B.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 15 1928 to March 6 1928*that I last saw him alive on *March 6 1928*and that death occurred, on the date stated above, at *8<sup>12</sup> p. m.*

The CAUSE OF DEATH\* was as follows:

*Hypertrophy Prostate*(duration) *2* yrs. mos. ds.CONTRIBUTORY  
(Secondary)*Cystitis, Nephritis Ch.*(duration) yrs. *2* mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *Feb 23, 1928*Was there an autopsy? *no*

What test confirmed diagnosis?

*Clinical*

(Signed)

*George B. Buel*, M. D.

, 19 (Address)

*Church Home & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVING*Presbyterian, Towson*

DATE OF BURIAL

*2/9 1928*

20 UNDERTAKER

*W. Cook*

ADDRESS

*507 E. North Ave*



31332

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31332

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST. *12-19* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *1819 St. Paul*

(Usual place of abode)

ST. *12-19* WARDLength of residence in city or town where death occurred *1/10* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X *male* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Marian Toomey*DATE OF BIRTH (month, day, and year) *Sept. 18, 1868*AGE Years *59* Months *4* Days *17* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Engineer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Lumber Co*BIRTHPLACE (city or town)  
(State or country) *Ind*10 NAME OF FATHER *Daniel Toomey*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Pa*12 MAIDEN NAME OF MOTHER *Rebecca Yeager*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Balto. Md*Informant  
(Address) *Laura B. Green*  
*114 Wyandale Ave*Filed *1928*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 5 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*2/17*, 19 *28*, to *3/5*, 19 *28*.that I last saw him alive on *3/5*, 19 *28*.and that death occurred, on the date stated above, at *8:05 P. M.*

The CAUSE OF DEATH\* was as follows:

*Large bilateral renal calculi  
to right pyelonephritis and partial  
left pyelonephritis*(duration) yrs. *2* mos. ds.

## CONTRIBUTORY

(Secondary)

*Toxemia* (duration) yrs. mos. *18* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes (partial)*What test confirmed diagnosis? *Tray of signs + lab.*(Signed) *J. MacLennan*, M. D., 19 (Address) *St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *St. Mary's Hospital*

DATE OF BURIAL

20 UNDERTAKER *Wm. Cook*ADDRESS *502 E. North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31333

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

70 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.

WARD

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

Married

married, widowed, or divorced

HUSBAND of

or) WIFE of

David Markley

DATE OF BIRTH (month, day, and year) Sept 28-1848

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

79

5

8

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John C. Sharp

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Rosina Franz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

Informant (Address)

David Markley  
4517 Harford Road

Filed

19

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1925, to March 6, 1928

that I last saw him alive on March 5, 1928

and that death occurred, on the date stated above, at

1045 A.M.

The CAUSE OF DEATH\* was as follows:

severe thrombosis of the heart

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

valvular disease of the heart

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? histologic

(Signed) H. Young, M. D.

Address 1618 Gorsuch St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

UNDERTAKER

William Cook

DATE OF BURIAL

3/9 1928

ADDRESS

502 E North

31334

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31334

PLACE OF DEATH

OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 26-37 WARD)FULL NAME Flourence E. Schuber

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE No. Spaulds, Maryland WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds.

?

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male whitemarriedmarried, widowed, or divorced  
HUSBAND of  
or) WIFE of

?

DATE OF BIRTH (month, day, and year)

?

YE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.5-1

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workhousewifeb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)BaltimoreMaryland

10 NAME OF FATHER ?

Bonds

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant  
(Address)Records

Filed

1928HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 3, 1928, to Mar. 5, 1928.that I last saw her alive on Mar. 5, 1928and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach(duration) yrs. 1 mos. ds.CONTRIBUTORY  
(Secondary)Pneumonia(duration) yrs. mos. 4 ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. J. Jones M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Baltimore

UNDERTAKER

W. M. Cook

DATE OF BURIAL

3/9/1928

ADDRESS

507 E. North St.

31335

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90E 31335

PLACE OF DEATH

OF BALTIMORE: (NO. 12-19 WARD)FULL NAME Dorrence Elliott

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE No. 1909 Barclay ST., WARD

(Usual place of abode)

th of residence in city or town where death occurred 42 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male white marriedmarried, widowed, or divorced  
HUSBAND of  
(or) WIFE ofEdward ElliottDATE OF BIRTH (month, day, and year) Aug 3-1885

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.4271

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workhousewifeb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland10 NAME OF FATHER Samuel Wells11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Seneca Wooden13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) MarylandInformant  
(Address)Records

Filed

1928C. H. JONES, Jr.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4/1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 28, 1928 to Mar 4, 1928,  
that I last saw her alive on Mar 4, 1928and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH\* was as follows:

mitral stenosis & myocarditis - acute & chronic  
auricular fibrillation. Rheu-  
matic. (duration) yrs. 6 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? General & Sub  
(Signed) C. J. Jones, Jr., M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALWestern Cemetery

UNDERTAKER

William Cook

DATE OF BURIAL

3/7/28

ADDRESS

502 E North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31336

## CERTIFICATE OF DEATH.

E 31336

## -PLACE OF DEATH

Y OF BALTIMORE: (No. 3106 Brighton ST. 28-64 WARD 4)

## -FULL NAME

Eileen M. Wagoner

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## a) RESIDENCE NO.

3106 Brighton ST.

## WARD

(Usual place of abode)

Length of residence in city or town where death occurred

10 yrs

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word)married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Jan 17 1925

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.121

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Balti-

10 NAME OF FATHER

H. Wilson Wagoner

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Emilie P. Wagoner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

Informant

(Address)

Mrs. Wilson Wagoner3106 Brighton St. Baltimore

Filed

AR 7 - 1928 JAMES JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 6 1925

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 28, 1928, to March 6, 1928,that I last saw her alive on March 4, 1928,and that death occurred, on the date stated above, at 3106

The CAUSE OF DEATH\* was as follows:

Whooping Cough

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

W. E. Breuninger

M. D.

, 19

(Address)

1013 Poplar Grove St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

St. Catharine's ChurchFeb 7 1925

20 UNDERTAKER

ADDRESS

Wm. C. 002 E. State St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31337

## CERTIFICATE OF DEATH.

31337

PLACE OF DEATH

Y OF BALTIMORE: (No.

FULL NAME

Harry Brown

RESIDENCE NO.

1029 Dorset St

(Usual place of abode)

Length of residence in city or town where death occurred

6 yrs. 4 mos. 28 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

Male

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Nov 9th 1922

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

4 3 24

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

none

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Bal Baltimore

10 NAME OF FATHER

Harry Brown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Bal

12 MAIDEN NAME OF MOTHER

Mary Fyler

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Bal

Informant  
(Address)

Records

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 4 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb-25, 1928, to Mar 4, 1928,  
that I last saw him alive on Mar 4, 1928,  
and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH\* was as follows:

acute suppurative arthritis  
mediastinitis  
Fibrinous pleurisy

(duration) yrs. mos. 9 ds.

CONTRIBUTORY  
(Secondary)

Septicemia

(duration) yrs. mos. 3 ds. (?)

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death?

yes. Date of Feb 28th 1928

Was there an autopsy?

yes

What test confirmed diagnosis?

Physical diagnosis

(Signed) William M. Miller M.D.

, 19 (Address) The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Baltimore Cemetery

DATE OF BURIAL

Mar 7 1928

20 UNDERTAKER

George Schilling &amp; Sons 1126 E. Mount St

31338

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33 E 31338

PLACE OF DEATH

OF BALTIMORE: (No. 3007 Jona Terrace ST. 8-44 WARD)

FULL NAME Webster L. Bierman

RESIDENCE NO. 3007 Jona Terrace ST.

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 23 ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White

Married

Married, widowed, or divorced  
HUSBAND of

Vera G. Bierman

DATE OF BIRTH (month, day, and year)

October 11, 1894

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

28

4

23

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

Real estate dealer

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)

(State or country)

Baltimore

Md

10 NAME OF FATHER

William J. Bierman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

Md

12 MAIDEN NAME OF MOTHER

Ella M. Collins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

Md

Informant

(Address)

Vera G. Bierman  
3007 Jona Terrace

Filed

1928

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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 5, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1926, to March 5, 1928.

that I last saw him alive on March 5, 1928.

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH was as follows:

Intestinal Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical &amp; laboratory

(Signed) H. K. Gandy

3-5-1928 (Address) 4218 Harford Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Greenmount Cemetery  
George Schilling & Sons

Mar 8, 1928

1120 E. Pratt St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

1339

## CERTIFICATE OF DEATH.

31 E 31339

## PLACE OF DEATH

Y OF BALTIMORE: (No.

-FULL NAME

a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 11 mos. 28 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

K

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male white

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

3-8-26

AGE

Years

Months

Days

If LESS than  
1 day... hrs.  
or... min.

1

22

28

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Md -

10 NAME OF FATHER

Leonard Bryant

11 BIRTHPLACE OF FATHER (city or town)

La -

(State or country)

12 MAIDEN NAME OF MOTHER

Christine Terich

13 BIRTHPLACE OF MOTHER (city or town)

Md -

(State or country)

Informant

(Address)

Records -

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 6 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 12, 1928, to March 6, 1928, that I last saw her alive on March 6, 1928, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY  
(Secondary)

(duration) 1 yrs. 7? mos. ds.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Alan Blossom

M. D.

, 19 (Address)

The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London. PK Ben

3/8 1928

UNDERTAKER

ADDRESS

J. Fero M. Gully, 1306 East An.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31340

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

2-OF BALTIMORE: (No.

3-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Feb 5, 1928, to March 4, 1928.

that I last saw her alive on March 4, 1928,

and that death occurred, on the date stated above, at 1:45 P.m.

The CAUSE OF DEATH\* was as follows:

Adeno Carcinoma body of Uterus. Phlebitis left lower extremity for 2 weeks

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 5 mos. ds.

18 Where was disease contracted

If not at place of death? 1601 N. Fulton Ave

Did an operation precede death? Yes Date of Feb 6-1928

Was there an autopsy? No

What test confirmed diagnosis? Clinical &amp; Surgical

(Signed) Sherman &amp; Garrett, M. D.

3-4, 1928 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Paul's Cathedral Cem.

Mar 8, 1928

20 UNDERTAKER

ADDRESS

Fred A. Turner &amp; Son 703 Hanover St

1928 HEALTH DEPARTMENT, BALTIMORE, MD. Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

Y OF BALTIMORE: (No.)

JOHNS HOPKINS HOSPITAL ST.

WARD)

FULL NAME

Elizabeth Cooks Young

(a) RESIDENCE NO.

1343 Ardmore

ST.

WARD

City

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

Black

married

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

24

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Ind -

10 NAME OF FATHER

Edison Young

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Informant

(Address)

Records -

JOHNS HOPKINS HOSPITAL

Filed 7-1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 5-1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 24, 1928, to March 5, 1928,  
that I last saw her alive on March 5, 1928,  
and that death occurred, on the date stated above, at 12:35 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration)

yrs.

mos.

6 ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

no

Date of

Was there an autopsy?

What test confirmed diagnosis?

Blood culture &amp; Sputum typing

(Signed)

C. H. Williams

M. D.

3-6-1928 (Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel Cemetery

20 UNDERTAKER

T. E. Nelson

DATE OF BURIAL

March 8 1928

ADDRESS

1343  
Prestman St.



# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 31342**

## CERTIFICATE OF DEATH.

**E 31342**

REGISTERED NO.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 1103 Stricker St. 16-22 Ward)

2-FULL NAME Milton Waters

(a) RESIDENCE NO. 1103 Stricker St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MALE

COLORED

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct. 6. 1923

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

4

4

28

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) BALTIMORE

(State or country)

MARYLAND

10 NAME OF FATHER RAYMOND WATERS

11 BIRTHPLACE OF FATHER (city or town) UNIONTOWN

(State or country)

CATOCHE CO. MD

12 MAIDEN NAME OF MOTHER HELEN DAVIS

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

BALTO. MD

14 Informant RAYMOND WATERS  
(Address) 1103 N. STRICKER ST.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

March 4

17

I HEREBY CERTIFY, That I attended deceased from Feb 28, 1928 to March 4, 1928

that I last saw him alive on March 3, 1928, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH was as follows:

Broncho pneumonia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds.

CONTRIBUTORY

(Secondary)

Tetanus  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 15 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? St. M. Card

(Signed) St. M. Card, M. D.

15, 1928 (Address) 2005 Druid Hill Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mount Zion Cemetery

2/7 1928

20 UNDERTAKER

ADDRESS

1503 Presbiterian St

J E Nelson

E 31343

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

102 E 31343

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 Guilford ST. 12-50 WARD)

FULL NAME Dorothy P. Owen

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 21009 Guilford ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE F W 5 Single, Married, Widowed, or Divorced, (write the word) M

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Guy Owen

DATE OF BIRTH (month, day, and year) Feb 6 86

AGE Years 42 Months 1 Days — If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Facial

(b) General nature of industry, business, or establishment in which employed (or employer) Work

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) Md.

10 NAME OF FATHER Juse Wagner

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Babylon

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Md.Informant  
(Address) Maude Wagner  
2109 Guilford

7-1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1928

17

I HEREBY CERTIFY That I attended deceased from Dec 31, 1925, to March 6, 1928.

that I last saw her alive on March 6, 1928

and that death occurred, on the date stated above, at 4:05 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic emphysema

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of 2/18/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Jones M. D.  
3/6, 1928 (Address) 720 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Meadow Branch

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

2238 W. North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31344

## CERTIFICATE OF DEATH.

31 E 31344

PLACE OF DEATH

Y OF BALTIMORE: (No. Baltimore City Hospitals ST. 19-27 WARD)FULL NAME Mamie Henderson

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

(a) RESIDENCE NO. 1514 W. Saratoga st. ST. \_\_\_\_\_ WARD \_\_\_\_\_  
 (Usual place of abode) Unknown mos. \_\_\_\_\_ ds. \_\_\_\_\_  
 Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
 How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE Colored 5 Single, Married, Widowed,  
 or Divorced, (write the word) Married

married, widowed, or divorced  
 HUSBAND of \_\_\_\_\_  
 (or) WIFE of William Henderson

DATE OF BIRTH (month, day, and year) 1899

AGE 29 Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
 If LESS than  
 1 day, \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Domestic(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Unknown(c) Name of employer UnknownBIRTHPLACE (city or town)  
(State or country) Virginia10 NAME OF FATHER Peter Tucker11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Virginia12 MAIDEN NAME OF MOTHER Adeline Irvin13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) GeorgiaInformant Hospital Records  
(Address)

Filed

1928

HAMILTON JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 19 28

17 I HEREBY CERTIFY, That I attended deceased from  
Nov. 25, 19 27, to March 4, 19 28,

that I last saw her alive on March 4, 19 28,and that death occurred, on the date stated above, at 1.15 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) Unknown  
 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

CONTRIBUTORY Pneumothorax  
(Secondary)

(duration) Unknown  
 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

18 Where was disease contracted  
if not at place of death? UnknownDid an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? YesWhat test confirmed diagnosis? Clinical & autopsy(Signed) [Signature], M. D.3-5-28 (Address Baltimore City Hospitals)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

31345

## CERTIFICATE OF DEATH.

31345

### 1-PLACE OF DEATH

TY OF BALTIMORE: (No. *1429 Riverside Ave* ST. *24-33* WARD *129E*)

### 2-FULL NAME

*Louis Franklin Morris*

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### (a) RESIDENCE NO.

(Usual place of abode)

*1429 Riverside ST.*

### WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *80* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### SEX

#### 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male*

*White*

*Married*

If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Lavinia Morris*

DATE OF BIRTH (month, day, and year)

*Nov 5 1846*

#### AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*81*

*4*

*3*

*26*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Police Officer*

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Pumptonia Md*

### 10 NAME OF FATHER

*Unknown*

### 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Unknown*

### 12 MAIDEN NAME OF MOTHER

*Unknown*

### 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*

Informant (Address)

*Alvin E. Reynolds 1429 Riverside Ave*

1928

C. HAMPTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 8 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 3 1928*

to

*Mar 5 1928*

that I last saw him alive on

*Mar 5 1928*

and that death occurred, on the date stated above, at

*70 m.*

The CAUSE OF DEATH\* was as follows:

*Old age*

### CONTRIBUTORY

(Secondary)

*Chronic cat nephritis*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

*no*

Did an operation precede death?

Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Phys*

(Signed)

*W. H. Heston*

M. D.

3/8 1928 (Address)

*1319 Light St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*London Park*

### 20 UNDERTAKER

*John H. Denny*

### DATE OF BURIAL

*Mar 8 1928*

### ADDRESS

*1319 Light St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31346

E 31346

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 19-27 WARD)

## 2. FULL NAME

Emma Johnson(a) RESIDENCE NO. 645 Kirby Lane

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 1 mos. 0 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD City

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

maleBlackMarried

married, widowed, or divorced

HUSBAND of

(or) WIFE of

Stanley Johnson

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

31

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Ind -

10 NAME OF FATHER

Edmund Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind -

12 MAIDEN NAME OF MOTHER

Emma Thayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind -

Informant (Address)

Records -

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 6 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1928, to March 6, 1928, that I last saw her alive on March 6, 1928, and that death occurred, on the date stated above, at 3:28 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma right ovary metastasis to omentum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes Date of 3-6-28  
Yes

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Ridgeway Trimble M. D.

19

(Address)

Johns Hopkins

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

W. C. Ruben

20 UNDERTAKER

Sam. W. Evans & Son

DATE OF BURIAL

Mar 9 1928

ADDRESS

1400 Maple



E 31347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002  
E 31347  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2115 S. Clifton St. 26-36 Ward)

2-FULL NAME *Geo. F. Hammelmann*

(a) RESIDENCE NO. 2115 S. Clifton St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 8 mos. 10 ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Oct. 14 1859*

AGE Years *68* Months *5* Days *4* IF LESS than 1 day.....hrs. or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

BIRTHPLACE (city or town) *Balto. Co.*  
(State or country) *City Annex*

10 NAME OF FATHER *Sebastian Hammelmann*

11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)

12 MAIDEN NAME OF MOTHER *Barbara Schlimbach*

13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)

14 Informant *Mary R. Teckley*  
(Address) *831 S. Third St.*

15 Filed *1925* 19 *12-23* Registrar *K. J. C.*

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 5 1925*

17 I HEREBY CERTIFY, That I took charge of the remains described above, held (inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said (inquest, autopsy or inquiry.)  
and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Arterio Sclerosis*  
(duration) yrs. 7 mos. 1 ds.

CONTRIBUTORY (Secondary) *Arterio Sclerosis*  
(duration) yrs. 1 ds.  
Signed *J. C. Stokes* M. D.  
(Address) *1438 B. B. Way*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Holy Redeemer Cemetery* Date of Burial *Oct 8 1927*

20 UNDERTAKER *Lilly & Zuercher Inc.* ADDRESS *4035 North St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31348 DEATH

City of BALTIMORE: (No. 420 D-12 St., 26 Ward)

2-FULL NAME Esther Reindel

(a) RESIDENCE NO. 420 D-12 St. 26 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of late Joseph Reindel (or) WIFE of

DATE OF BIRTH (month, day, and year) March 9, 1886

AGE Years 79 Months 11 Days 27 IF LESS than 1 day.....hrs. or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... Retired  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

BIRTHPLACE (city or town) Germany  
(State or country)

10 NAME OF FATHER Leont Kueck

11 BIRTHPLACE OF FATHER (city or town).....  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Esther Madra

13 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) Germany

14 Informant Mary Elizabeth Markel  
(Address) 420 D-12 St

15 Filed 1928 HANCOCK JONES, H. Registrar

REGISTERED 31348

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry.

Whereon and from the evidence obtained by said inquest, autopsy or inquiry, I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary) of L. Austin

(Signed) M. D. 7/28 (Address) 1438 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Sacred Heart Cem March 19 28

UNDERTAKER Willy Ziehl Inc. ADDRESS 4034 Woz St

31349

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31349

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

Y OF BALTIMORE (No. *Baltimore Hospital No-37* ST. WARD)FULL NAME *Josephine Ballinger*(a) RESIDENCE NO. *3409 Harwood Ct.* ST. *26* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Married*

married, widowed, or divorced

HUSBAND of (or) WIFE of

*Thomas Ballinger*

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*46**47*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*John Ballinger*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Dorothy Loebe*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

Informant

(Address)

*Thomas Ballinger**3409 Harwood Court*

Filed

1928

JAN 20 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 4 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*2-17-1928* to *3-4-1928*that I last saw him alive on *3-4-1928*and that death occurred, on the date stated above, at *4:00* m.

The CAUSE OF DEATH\* was as follows:

*Coronary Artery*

CONTRIBUTORY (Secondary)

*Ischemic Heart Disease*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

*Physical Signs*

(Signed)

M. D.

19 (Address)

*Baltimore City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery**March 8 1928*

20 UNDERTAKER

ADDRESS

*Lilly Ziehl Inc.**4030 W. 11th*

31350

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31350

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

## 2-FULL NAME

(a) RESIDENCE NO. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

3

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST. \_\_\_\_\_

WARD \_\_\_\_\_

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Married

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mrs. Harry M. Canby

DATE OF BIRTH (month, day, and year)

June 17, 1874

AGE

Years

Months

Days

54

8

20

If LESS than 1 day, .... hrs or .... min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wholesale lumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

Wilmington, Del.

10 NAME OF FATHER

William M. Canby

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Edith Matthews

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ohio

Informant

(Address)

Record, Union Memorial Hospital

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 4, 1928, to March 7, 1928,

that I last saw him alive on March 7, 1928,

and that death occurred, on the date stated above, at 7:40 a. m.

The CAUSE OF DEATH\* was as follows:

Post operative Peritonitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Peritonitis

(duration)

yrs.

mos.

ds.

2

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of Mar. 5, 1928

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

A. Fisher

M. D.

Mar. 7, 1928 (Address) 715 Park Ave, Balto. Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

Mar 7 1928

ADDRESS

Henry J. Gunkel, 1000 E. Baltimore St., Baltimore, Md.

Filed

1928

H. J. Gunkel

Registered



31351

HEALTH DEPARTMENT - CITY OF BALTIMORE

31351

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 574 N Caroline ST., 7-9 WARD)

2. FULL NAME

(a) RESIDENCE NO. 514 N Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX 2 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

Benj Fisher

DATE OF BIRTH (month, day, and year) Mar. 15, 1880

AGE Years 47 Months 3 Days 20 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Balt Md

10 NAME OF FATHER

Daniel E Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Esther W Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

Informant (Address)

John E. Jones 514 N Caroline

Filed

1928

HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1928, to Mar 5, 1928, that I last saw her alive on Mar 4, 1928, and that death occurred, on the date stated above, at 8:00 pm.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency Arterio-sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? no place

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hematol

(Signed) J. E. Jones M. D.

, 19 (Address) 38 N Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Robert A. Jones Undertaker

Mar 8 1928 ADDRESS

Robert A. Jones 1515 M Elder St



E 31352

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31352

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 737 Forrest St., 10-15 Ward)2-FULL NAME John. J. Snyder(a) RESIDENCE NO. 737 Forrest St. 10-15 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 6 mos. 4 da.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth 48 yrs. 6 mos. 4 da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX Male4 Color or Race White5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced

HUSBAND of Christina B. Snyder  
(or) WIFE ofDATE OF BIRTH (month, day, and year) Aug. 22 1879

7 AGE

Years 48Months 6Days 14IF LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employed in(b) General nature of industry, business, or establishment in which employed (or employer) Refrigerating Plant

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

10 NAME OF FATHER Christopher Snyder11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Antonia Benville13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. Md.

(State or country)

14

Informant Mr. Christina B. Snyder  
(Address) 737 Forrest

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 5, 1928, to March 6, 1928that I last saw him alive on March 6, 1928and that death occurred, on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH\* was as follows:

AphasiaCONTRIBUTORY (Secondary) Emphysema of lungs

18 Where was disease contracted.

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. S. [unclear] M. D.Feb 7, 1928 (Address) 1834 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul CemeteryDate of Burial March 9 192820 UNDERTAKER Henry Beck LowADDRESS 1301 E Bay St

AR 7 - 1928 C. HAMPTON JONES, Registrar

# Douthat

## HEALTH DEPARTMENT—CITY OF BALTIMORE

81353

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2141 W North ave ST. 15-68 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 2141 W North ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

married, widowed, or divorced

HUSBAND of (or) WIFE of

Ellen Douthat

DATE OF BIRTH (month, day, and year) Dec 16 - 1873

AGE 54 Years 2 Months 18 Days/9 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Wm Douthat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Mary Walton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

Informant Ellen Douthat (Address) 2141 W North ave

Filed 1926 19 C. HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar 4 1928 to Mar 5 1928, that I last saw him alive on Mar 5 1928 and that death occurred, on the date stated above, at 2:30 p. m. The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia (Right)

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Odema of lungs + bronchial asthma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. M. Wheeler, M. D.

3-5-28 (Address) 2029 W. Mt. Airy

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

DATE OF BURIAL March 5 1928 ADDRESS 1962 Broadway

UNDERTAKER Robt Y Turner Jr

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31354

E 31354  
PLACE OF DEATHCITY OF BALTIMORE: (No. 2806 Grindon Ave ST. 77 WARD)2-FULL NAME Howard H. Nichols

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2806 Grindon Ave ST. 77 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Marriedmarried, widowed, or divorced  
HUSBAND of  
(or) WIFE ofHilda E. Ludwig  
DATE OF BIRTH (month, day, and year) Oct 9, 1894AGE 33 Years 4 Months 28 Days 26 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Philadelphia  
(State or country)10 NAME OF FATHER Harry H. Nichols11 BIRTHPLACE OF FATHER (city or town) New Jersey  
(State or country)12 MAIDEN NAME OF MOTHER Margaret Vandenberg13 BIRTHPLACE OF MOTHER (city or town) Philadelphia  
(State or country)Informant Mrs. Hilda E. Nichols  
(Address) 2806 Grindon AveFiled 7-1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 192817 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1928, to Mar 5, 1928, that I last saw him alive on Mar 4, 1928, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Hypertension & Myocarditis  
(duration) yrs. mos. ds.CONTRIBUTORY Coronary Embolus  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 25, 1928Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clara J. Smith, M. D.  
(Address) 4202 Hopkins Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
BURYAL Parkwood Ave20 UNDERTAKER John UelrichDATE OF BURIAL Mar 8 1928  
ADDRESS 2008 Calver

31355

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31355

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *Bow Secour Hospital 20-27* ST. *WARD*)

## 2-FULL NAME

(a) RESIDENCE No. *St. Charles College Catonsville* ST. *WARD*

(Usual place of abode)

Length of residence in city or town where death occurred *25* yrs. — mos. — ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE *male White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *unknown 1862*AGE Years Months Days If LESS than 1 day, hrs. or min. *66 — —*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Cleveland Ohio*10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *unknown*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *unknown*Informant (Address) *Rev Eugene Harrison St. Charles College*Filed *1928*

HAMPSON JONES, H. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 6<sup>th</sup> 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 2*, 1928, to *Mar 6*, 1928,that I last saw him alive on *Mar 6*, 1928,and that death occurred, on the date stated above, at *5:45 A m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage  
Arterio Sclerosis  
Pulmonary Tuberculosis*(duration) yrs. mos. *23* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31356

## CERTIFICATE OF DEATH.

E 31356

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 N. Broadway

ST., 8-17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Elizabeth K. Twamley.

## (a) RESIDENCE No.

1724 N. Broadway

ST., WARD

(Usual place of abode)

Lifetime

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

William P. Twamley.

DATE OF BIRTH (month, day, and year)

Jan. 19th, 1861

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

67

1

15

16

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

10 NAME OF FATHER John H. Knowles

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Gordon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany.

Informant

Lillian Twamley Cullen.

(Address)

1724 N. Broadway

Filed

1928

G. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 5th, 1928.

17

HEREBY CERTIFY, That I attended deceased from

July 19, 1927, to March 5, 1928.

that I last saw her alive on March 5, 1928

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. K. M. D.

19 (Address) 1812 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery.

3/ 8 1928.

ADDRESS

Chas. P. Wauson 118 W. 11th St. Baltimore



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31357

## CERTIFICATE OF DEATH.

90 E 31357

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2614 E. Baltimore St., 6-10 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine T. Becker

(a) RESIDENCE NO. 2614 E. Baltimore

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

March 3, 1859,

AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69		3	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

Va.

10 NAME OF FATHER

Michael Hoy

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Ellen Hughes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Scotland

14

Informant

(Address)

Miss Lillie Becker  
Richmond Va.

15 1928 C. HAMPSON JONES, M. D.

Reg

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

Mch 6 1928

17

I HEREBY CERTIFY, That I attended deceased from

11-1-1927 to 3-6-1928

that I last saw him alive on 3-4-1928

and that death occurred, on the date stated above, at 2:05 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis &  
arteriosclerosis and hypertension

(duration) yrs. 5 mos. 5 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Bawden, M. D.

3/6, 1928 (Address) 1517 E. North

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of burial

Richmond Va. Mch 8 1928

20 UNDERTAKER

ADDRESS

Jm. B. Black 927 N. Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31358

## CERTIFICATE OF DEATH.

E 31358

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital 11-24* ST. *11-24* WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
2/28, 1928, to March 2, 1928

that I last saw him live on March 2, 1928

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH\* was as follows:

Senile arteriosclerosis  
hypertension  
Chronic interstitial nephritis  
Congestive heart failure  
PneumoniaCONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Physical Sign

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER Health.

E. WOODALL

Daniel Carter 916

ADDRESS

1928

MAR 5 - 1928

1928

C. HAMPTON JONES, M. D.  
Registrar

31359

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31359

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 Forrest St. 5-8 WARD)2. FULL NAME Baby Jackson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 331 Forrest

(Usual place of abode)

ST. Forrest WARD 5-8

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Male Black6 married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) Feb. 16, 1928

AGE

Years

Months

Days

If LESS than  
1 day, 2 hrs.  
or 2 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) Md.10 NAME OF FATHER Lawrence Jackson11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Md.12 MAIDEN NAME OF MOTHER Elizabeth Vaneval13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Va.Informant  
(Address)Edw. Williams M.D.File 1928CHAMBERLAIN JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 19 28

17

I HEREBY CERTIFY, That I attended deceased from

2-16, 19 28, to 2-16, 19 28that I last saw him alive on 2-16, 19 28and that death occurred, on the date stated above, at 11:00 A. m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edw. Williams, M. D.

3-5, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

HOPKINS HOSPITAL 7-1928

20 UNDERTAKER

ADDRESS

Commissioner Health

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31360

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No.

Johns Hopkins Hospital.

ST. 15-23 WARD)

## 2-FULL NAME

Baby Cook

## (a) RESIDENCE NO.

1343

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Black

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Feb. 29, 1928

AGE

Years

Months

Days

If LESS than  
1 day 10 hrs.  
or 30 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

Oliver Cook

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

Elizabeth Young

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

C. HAMPTON JONES, M.D.

1928

C. HAMPTON JONES, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 1, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 29, 1928, to 3-1, 1929,

that I last saw her alive on 3-1, 1929

and that death occurred, on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. Hampton Jones, M. D.

3-5, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

MAR 1 1928

Commissioner Health.

HEALTH DEPARTMENT—CITY OF BALTIMORE **E 31361****31361**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. **BALTIMORE CITY HOSPITAL** **ST. 14-20** WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME **Clarence Ransom**(a) RESIDENCE NO. **1529 Seinfeld Alley** WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred **7** yrs. **0** mos. **0** ds. How long in U. S., if of foreign birth? **0** yrs. **0** mos. **0** ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX **Male** 4 COLOR OR RACE **Caucasian** 5 Single, Married, Widowed, or Divorced, (write the word) **Married**If married, widowed, or divorced HUSBAND of or WIFE of **?**DATE OF BIRTH (month, day, and year) **?**AGE **33** Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **Waterman**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) **Virginia**10 NAME OF FATHER **Clarence Ransom**

11 BIRTHPLACE OF FATHER (city or town)

(State or country) **Virginia**12 MAIDEN NAME OF MOTHER **Molly ?**

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) **Virginia**Informant (Address) **Records****1928****C. HAMPTON JONES, M. D.**

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **3/3/1928**

17

I HEREBY CERTIFY, That I attended deceased from **Feb. 24, 1928, to Mar. 3, 1928.** that I last saw him alive on **Mar. 3, 1928,** and that death occurred, on the date stated above, at **3:00 P. m.** The CAUSE OF DEATH\* was as follows:**Sudden pneumonia**(duration) yrs. mos. **12** ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? **no** Date ofWas there an autopsy? **no**What test confirmed diagnosis? **General & Sub**(Signed) **C. Jones, M. D.**

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

**JOHNS HOPKINS HOSPITAL**  
**Commissioner Health****MAR 7 - 1928**



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31362

## CERTIFICATE OF DEATH

E 31362

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 38)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

6 If married, widowed, or divorced HUSBAND of or WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 2-25, 1928, to 3-4, 1928.

that I last saw him alive on 3-3, 1928.

and that death occurred, on the date stated above, at 11:05 A. M.

The CAUSE OF DEATH\* was as follows:

General Paralysis of Insane  
Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Registrar

Commissioner of Health

MAR 7 - 1928

31363

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31363

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hosp* ST. *4-7* WARD)

## 2. FULL NAME

*Mr. George S. Williams*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*Emerson Hotel*

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *63* yrs. *6* mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*

If married, widowed, or divorced HUSBAND of (or) WIFE of

*Mrs. George S. Williams*

DATE OF BIRTH (month, day, and year)

*Feb 6 1864*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*63**6*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*United Railways*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Md.*

## 10 NAME OF FATHER

*E. L. Williams*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

## 12 MAIDEN NAME OF MOTHER

*Kate Shipley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

14

Informant (Address)

*R. Brooks*  
*Cathoon Hollins*

15

1828

19

Per

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-6*19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 28*, 19 *28*, to *March 6*, 19 *28*.that I last saw *him* alive on *March 6*, 19 *28*.and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Bladder**(over)**Unknown* (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Uremia & Pyelitis*

(duration)

yrs.

mos.

ds. *6 mos*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

*Autopsy*

(Signed)

*Frank Taylor Morris M. D.*

, 19

(Address)

*Union Mem Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Salisbury Md**May 29*

20 UNDERTAKER

*Robert Brookson**Cathoon Hollins*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31364

100 E 31364

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1311 Hanover)

2-FULL NAME Lawrence McCoy Eagan Jr.

(a) RESIDENCE NO. 1311 Hanover

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 Color or Race

White

5 Single, M

? Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

7 AGE

Years

4

Months

8

Days

19

IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Lawrence M. Eagan

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Balto., Md.

12 MAIDEN NAME OF MOTHER

Irma Gurnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14 Informant L. M. Eagan (Address) 1311 Hanover St.

15 1928

C. HAMMON JONES, JR. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

St. Ward

(If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 28

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1928, to Mar 5, 1928 that I last saw him alive on Mar 5, 1928 and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Bronchopneumonia Primary

CONTRIBUTORY (Secondary)

Exhaustion (duration) yrs. mos. 6 da.

18 Where was disease contracted (duration) yrs. mos. 1 da.

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Campbell, M. D.

1644 Hanover

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cem.

20 UNDERTAKER Margaret H. Lynn

Date of Burial

March 8 1928

ADDRESS

1422 Light St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31365

## CERTIFICATE OF DEATH.

E 31365

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1475 Keule St* ST. *24-35* WARD *101*)2-FULL NAME *Michael J. Flynn*(a) RESIDENCE NO. *1475 Keule* ST. *24-35* WARD *101*

(Usual place of abode)

Length of residence in city or town where death occurred *38* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male.**White**Married*

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

*Mary Flynn*DATE OF BIRTH (month, day, and year) *1867*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*61*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Ireland*10 NAME OF FATHER *Patrick Flynn*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*12 MAIDEN NAME OF MOTHER *Bridget Goughlin*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

14

Informant (Address)

*Mary Flynn*  
*1475 Keule St*

15

1928

G. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mich. 2, 1928*, to *Mich. 6, 1928*.that I last saw him alive on *Mich. 6, 1928*.and that death occurred, on the date stated above, at *4450* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*  
*Chorea*(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

*Ch. Interstitial Nephritis*(duration) yrs. mos. *5* ds.

18 Where was disease contracted if not at place of death?

*No*

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Smear*

(Signed)

*Thos. J. A. Dennis, M. D.*

3/7, 1928 (Address)

*2878 Haverford Rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Cathedral Cem.*

DATE OF BURIAL

*March 9 1928*

20 UNDERTAKER

*Margaret H. Flynn*

ADDRESS

*1475 Keule St*

31366

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31366

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE, MD.

### 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant

(Address)

File

1920 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

March 1st, 1928, to March 5, 1928,

that I last saw him live on March 5, 1928,

and that death occurred, on the date stated above, at 7:15 A. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. J. Hall, M. D.

19 (Address) 4246 23rd St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS



31367

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Female

White

Married

If married, widowed, or divorced  
HUSBAND of  
WIFE of

John J. Williams

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 23, 1928, to Mar 7, 1928.

that I last saw her alive on Mar. 7, 1928,  
and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

CONTRIBUTORY  
(Secondary)

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

3/368 HEALTH DEPARTMENT-CITY OF BALTIMORE 3/368

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3220 W Garrison Ave. 15-64 WARD)

2. FULL NAME Susie C. Nichols

REGISTERED NO. 90  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 3220 Garrison Ave. ST. WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of or WIFE of

DATE OF BIRTH (month, day, and year) Aug 7, 1851  
AGE Years 76 Months 7 Days 0 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER John Nichols.

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Mobray

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

Informant Lawrence N. Frampton (Address) 3220 Garrison Ave.

R-8 - 1928 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1928 to Mar 7, 1928 that I last saw her alive on Mar 7, 1928 and that death occurred, on the date stated above, at 8:10 P. M.

The CAUSE OF DEATH\* was as follows:  
Cerebral Embolism

(duration) yrs. mos. 7 ds.  
CONTRIBUTORY Chronic Endocarditis (Secondary) (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Lawrence N. Frampton M. D. (Address) 3220 Garrison Ave. P.O. Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Spring Hill Cem. Easton, Md. UNDERTAKER W. Cook

DATE OF BURIAL

Mar 8 1928

ADDRESS

5025 North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31369

## CERTIFICATE OF DEATH.

49 E 31369

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Barclay St. 12-19)

## 2. FULL NAME

Charles Henry Houck

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1602 Barclay

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 8 mos.

ST. WARD

ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

EX 4 COLOR OR RACE 7 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced, HUSBAND or (or) WIFE of

DATE OF BIRTH (month, day, and year) 5-4-55 10-19-1904

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

1928

C. H. JONES, JR.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from 18 Feb 18, 1927, to March 5, 1928, that I last saw him alive on March 5, 1928, and that death occurred, on the date stated above, at 4:40 p.m. The CAUSE OF DEATH\* was as follows:

Cancer of Bladder

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 1 mos. 8 ds.

18 Where was disease contracted (duration) yrs. mos. ds. If not at place of death?

Did an operation precede death? yes Date of 7/12/27 Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/6, 1928 (Address) 7012 Barclay M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

31370

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31370

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *902 Buck's Lane* St. *28-63* Ward)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Minnie M. Filbert*

(a) Residence No. *902 Buck's Lane* St. .... Ward. ....

(Usual place of abode)

(If non resident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. .... mos. .... ds.

How long in U. S. if of foreign birth? yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS.

SEX *M*

4-COLOR OR RACE *W*

5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-If married, widowed, or divorced, HUSBAND of (or) WIFE *John H. Filbert*

7-DATE OF BIRTH (month, day and year) *Apr 4, 1883*

8-AGE *44* yrs. .... mos. .... ds.

If LESS than 1 day, .... hrs. or .... min.?

9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. .... *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer). .... *037*

(c) Name of employer. ....

10-BIRTHPLACE (city or town) (State or Country). .... *Md*

11-NAME OF FATHER *William Chumney*

12-BIRTHPLACE OF FATHER (city or town) (State or Country). .... *Md*

13-MAIDEN NAME OF MOTHER *Rebecca Davis*

14-BIRTHPLACE OF MOTHER (city or town) (State or Country). .... *Md*

15-

(Informant) *John H. Filbert*

(Address) *902 Buck's Lane*

16-

Filed *1928*

C. HAMPTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *Mar 6, 1928*

17- I HEREBY CERTIFY, That I attended deceased from *Oct 1*, 19 *27* to *Mar 6*, 19 *28*

that I last saw her alive on *Mar 2*, 19 *28*

and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Breast + Adenoma*

(Duration) *1* yrs. .... mos. .... ds.

CONTRIBUTORY *Melastosis of Brain*

(Secondary)

*Anaemia* (Duration) *3* yrs. .... mos. .... ds.

18-Where was disease contracted *at place of death*

If not at place of death?

Did an operation precede death? *no* Date of *x*

Was there an autopsy? *no*

What test confirmed diagnosis? *Stethoscopic*

(Signed) *J. Hunt* M. D.

, 19 (Address) *Glyndon Rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL *Grind Ridge*

DATE OF BURIAL *3/8*, 19 *28*

20-INTERURKER *J. M. Cook*

ADDRESS *507 E. North Ave*



# HEALTH DEPARTMENT—CITY OF BALTIMORE

31371

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1. PLACE OF DEATH

CITY OF BALTIMORE (No. *Franklin Sq Hospital* ST. *20-69* WARD)

### 2. FULL NAME

*Graham Thumbert*

(a) RESIDENCE NO. *19 S. Harrison Lane* ST. *Life* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State) yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

*Male*

*White*

*Single*

If married, widowed, or divorced

HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*Apr 2, 1912*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*15*

*11*

*2*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore Maryland*

10 NAME OF FATHER

*James Thumbert*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

*Mattie Suggs*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*Hospital Records*

15

1928 C. HAMPSON JONES, M.D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-6-28* 19

17

I HEREBY CERTIFY, That I attended deceased from *10-31-27*, 19, to *3-6-28*, 19

that I last saw him alive on *3-6-28*, 19

and that death occurred, on the date stated above, at *955 p.m.*

The CAUSE OF DEATH\* was as follows:

*Sarcoma of left ilium and head of femur*

(duration) yrs. *5* mos. ds.

CONTRIBUTORY (Secondary)

*Secondary Duration of Left Hip joint - Myocardial Infarction*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Home*

Did an operation precede death?

*yes* Date of *11-5-27*

Was there an autopsy?

What test confirmed diagnosis?

*Clinical*

(Signed)

*Facil M. Hall*

M. D.

, 19 (Address) *Franklin Square Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park*

*3/9 1928*

20 UNDERTAKER

*Wm. Cook*

ADDRESS

*577 E. North Ave*



E 31372

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3650 Cedar Ave ST. 3-52 WARD)

2-FULL NAME: Flourance L Brooks

(a) RESIDENCE NO. 3650 Cedar Ave ST. 3-52 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 22, 1925  
AGE 2 Years 2 Months 15 Days If LESS than 1 day, 0 hrs. 0 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) md.  
(State or country)

10 NAME OF FATHER Jesse E. Brooks

11 BIRTHPLACE OF FATHER (city or town) md.  
(State or country)

12 MAIDEN NAME OF MOTHER Jessie M. Mason

13 BIRTHPLACE OF MOTHER (city or town) md.  
(State or country)

Informant Jessie E. Brooks  
(Address) 3650 Cedar Ave

1928 G. HAMPTON JONES, R. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1928, to Feb 7, 1928, that I last saw him alive on Feb 7, 1928, and that death occurred, on the date stated above, at 2:30 m. The CAUSE OF DEATH\* was as follows:

Suppuration

(duration) 3 yrs. 0 mos. 0 ds.  
CONTRIBUTORY Sancho Pneumonia  
(Secondary) (duration) 6 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Smear  
Signed Bevon F. Kelly M.D. M. D.

1, 1928 (Address) 4 Towson Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St Marys Hospital

March 9, 1928

20 UNDERTAKER

ADDRESS

Chenoweth

3615 Chestnut

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31373

## CERTIFICATE OF DEATH.

90 E 31373

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3540 Fall Road 13-57 St. Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 3540 Fall Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

R 8 Filed 1926 HAMMON JONES, Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6 1926

17

I HEREBY CERTIFY That I took charge of the

remains described above, held

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

autopsy or inquiry, and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Coronary Disease  
of Heart

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signature) ..... M. D.

3/6 1926 (Address) 3532 Roland

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

St Marys Hospital Mon 10 1926  
3539 Fall Road

31374

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31374

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 W Woodland 27-56 WARD)

2-FULL NAME Mary K Bollman

(a) RESIDENCE NO. 236 W Woodland av ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 86 mos. 0 ds. How long in U. S., if of foreign birth? yrs. 0 mos. 0 ds. (If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1842

AGE Years 86 Months 0 Days 0 If LESS than 1 day, hrs. 0 or min. 0

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Francis A DeMangin

11 BIRTHPLACE OF FATHER (city or town) France (State or country)

12 MAIDEN NAME OF MOTHER Elmyra Clark

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mary K. Bollman (Address) 236 West Woodland av

15 Filed 1928 19 APR 11 1928 Registrar R. H. H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 19 28

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 19 28, to Mar 7 19 28, that I last saw her alive on Mar 7 19 28, and that death occurred, on the date stated above, at 4:40 A. m.

The CAUSE OF DEATH\* was as follows:

Sclerosis hypertensiva

(duration) yrs. 3 mos. 0 ds. CONTRIBUTORY Chronic Valvular Hypertension (Secondary)

(duration) yrs. 5 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms (Signed) William H. Park M. D.

, 19 (Address) 2101 Gaymount Rd. S. E.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Green Mount Cemetery DATE OF BURIAL March 9 1928

UNDERTAKER Mary Syron ADDRESS 4415 Park Heights av

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31375

## CERTIFICATE OF DEATH.

17E 31375

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Not to be filled in)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

white

single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

unmarried

DATE OF BIRTH (month, day, and year)

Jan 26 1844

AGE

Years

Months

Days

84

1

9

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sister of Notre Dame

(b) General nature of industry, business, or establishment in which employed (or employer)

Teacher of French

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

West Indies

## 10 NAME OF FATHER

Raymond J. Agnew

## 11 BIRTHPLACE OF FATHER

West Indies

(State or country)

## 12 MAIDEN NAME OF MOTHER

Angelina Bousquet

## 13 BIRTHPLACE OF MOTHER

West Indies

(State or country)

14

Informant (Address)

Dr. H. B. Agnew

15

Filed

1928

H. B. Agnew, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 6 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 15 1928, to Mar 6 1928.

that I last saw her alive on Mar 5 1928,

and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clara J. Smith

M. D.

(Address)

4706 Harper Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Gorenshtown Private Cem

March 9 1928

## 20 UNDERTAKER

ADDRESS

Frank A. Fink

916 N. Gay St



E 31376

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61-001 ✓

## CERTIFICATE OF DEATH

E 31376

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2244 Combridge ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 2244 Combridge

(Usual place of abode)

ST. 13 WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed, or divorced HUSBAND of (or) WIFE of Still bornDATE OF BIRTH (month, day, and year) Feb 6 - 28

AGE

Years

Months

Days

If LESS than 1 day, hrs. or 5 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

G. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6, 1928

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31377

## CERTIFICATE OF DEATH.

129 E 31377

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4803 Gayman Ave. ST. 28-64 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ella M. Timley

## (a) RESIDENCE NO.

4803 Gayman Ave. ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

Female white

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Frederick S. Timley Sr.

## DATE OF BIRTH (month, day, and year)

Aug. 24-1850

## AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

77

6

12

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Martin J. Sparklin

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Ruth Ann Mott

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

## 14

Informant  
(Address)Frederick S. Timley  
4803 Gayman Ave.

## 15

Filed

1928

C. HANCOCK JONES, JR.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 6 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

May 1922 to Mar 6 1928

that I last saw him alive on Mar 6 1928

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis +  
Cardiac valvular insufficiency

(duration) about 6 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Cerebral redness

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

urinal tests

(Signed) H. E. Knapp M. D.

(Address) 4025 Edmondson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

London Park Cem. Mar. 8 1928

## 20 UNDERTAKER

## ADDRESS

Chas. E. Franck 802 Madison Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31378

## CERTIFICATE OF DEATH

31  
REGISTERED 31378

1-PLACE OF DEATH

City of BALTIMORE: (No. *200 N. Bond* St., *6-9* Ward)2-FULL NAME *Alexander Rockrow*(a) RESIDENCE NO. *200 N. Bond* St., *6-9* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. *11* mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*M.**C**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1916*

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

*12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*School Boy*

9 BIRTHPLACE (city or town)

(State or country)

*S.C.*

10 NAME OF FATHER

*Hinsey Rockrow*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Borgess*

12 MAIDEN NAME OF MOTHER

*Eliza M. Duffy*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Georgia*

14

Informant (Address)

*Eliza Rockrow*  
*200 N. Bond St*

15 Filed

19

JAMES JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/7 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 3, 1928*, to *Mar 7, 1928*that I last saw him alive on *Mar 3, 1928*and that death occurred, on the date stated above, at *4 A.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Phthisis*(duration) yrs. mos. *4* da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*J. J. Jones*, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Asbury cemetery**March 9, 1928*

20 UNDERTAKER

ADDRESS

*Edward Bryan**1631 Orleans St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31379

## CERTIFICATE OF DEATH.

Registered No. ....

## 1-PLACE OF DEATH

City of BALTIMORE: (No. .... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) Residence No. .... St., ... Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds.

How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced. (Write the word.)

a-If married, widowed, or divorced HUSBAND of (or) WIFE of

-DATE OF BIRTH (month, day and year)

-AGE,

If LESS than 1 day,

... hrs. or ... min.?

## OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town), (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (city or town), (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (city or town), (State or Country),

14-

(Informant)

(Address)

15-

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

17- I HEREBY CERTIFY, That I attended deceased from March 4, 1928, to March 7, 1928,

that I last saw him alive on March 6, 1928,

and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D. 9/7, 1928 (Address) 305 N. Pitt St. Rk 2

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 31380

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Franklin Square Hosp ST. 19-76 WARD)

## 2-FULL NAME

Frank McVey

## (a) RESIDENCE NO.

430 F Street Sparrows Point WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Catherine McVey

DATE OF BIRTH (month, day, and year)

Sept 5 1879

AGE

48

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

49

6

1

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist furman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Bethlehem Steel

BIRTHPLACE (city or town)  
(State or country)

Maryland

## 10 NAME OF FATHER

John McVey

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Martha Hoops

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

14

Informant  
(Address)

Hospital Records

15

File

1928

G. H. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-6-28, 19

17

I HEREBY CERTIFY, That I attended deceased from 2-28-28, 19 to 3-6-28, 19

that I last saw him alive on 3-6-28, 19

and that death occurred, on the date stated above, at 6:40 A.M.

The CAUSE OF DEATH\* was as follows:

Generalized Peritonitis  
(Ruptured Duodenal Ulcer)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted  
if not at place of death? Home

Did an operation precede death? yes Date of 2-28-28

Was there an autopsy?

What test confirmed diagnosis? Clinical  
(Signed) Cecil M. Hall, M. D.

3/6/28 (Address) Franklin Square Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Oak Lawn

DATE OF BURIAL

3/9/1928

20 UNDERTAKER

John G. Connelly

ADDRESS

Cessex







# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31382

## CERTIFICATE OF DEATH.

E 31382

### 1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL  
CITY OF BALTIMORE: (No. *Charles*)

2-FULL NAME *William Patterson*

(a) RESIDENCE No. *708 N. Mount*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1* mos. *14* ds.

ST., WARD

(If non-resident give city or town and State)  
yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *black* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Not known*

DATE OF BIRTH (month, day, and year) *3-1-1883*

AGE *45* Years *44* Months *4* Days If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Miner*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *W. Va.*

10 NAME OF FATHER *Charles Patterson*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *W. Va.*

12 MAIDEN NAME OF MOTHER *Hattie Jones*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *W. Va.*

Informant *Records*  
(Address)

AR 8 - 1928

JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.  
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 5-1928*

17 I HEREBY CERTIFY, That I attended deceased from *Jan 13, 1928*, to *March 5, 1928*, that I last saw him alive on *March 5, 1928*, and that death occurred, on the date stated above, at *5:45 P. m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of liver*

(duration) yrs. *5* mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis? *Autopsy*

(Signed) *James Bradley* M. D.

3-7-1928 (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE-

### DATE OF BURIAL

*McKeesport Pa*

*3/8 1928*

### UNDERTAKER

*D. C. Barton*

*Shatunice*

31383

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: No. *513 E Regester St* WARD *2-4*

2-FULL NAME *Herman Maliszewski*

(a) RESIDENCE No. *513 E Regester St* ST. *2* WARD *4*

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *child*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Sept. 30-27*  
AGE Years Months Days If LESS than 1 day, hrs. or min. *5 7*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Baltimore Md*

10 NAME OF FATHER *Julius*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*

12 MAIDEN NAME OF MOTHER *Osieska*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Poland*

Informant (Address) *Julius Maliszewski 513 E Regester St*

Filed

*W. H. Jones, M. D.* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 7 1928*

17 I HEREBY CERTIFY, That I attended deceased from *March 6, 1928*, to *March 7, 1928*, that I last saw him alive on *March 7, 1928*, and that death occurred, on the date stated above, at *5 p. m.* The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency.*

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) *Broncho-pneumonia* (duration) yrs. mos. ds. *3*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *P. S. & S.* (Signed) *John V. Seibert, M. D.* (Address) *1738 Eastern Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Rosary March 8 1928*

20 UNDERTAKER *W. H. Jones, M. D.* *W. H. Jones, M. D.* *W. H. Jones, M. D.*

11434  
E 31384

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

37-001  
E 31384

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JAMES HOPKINS HOSPITAL ST. 76-1 WARD)

### 2-FULL NAME

Catherine Donnelly

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### (a) RESIDENCE No.

3211 Hudson ST.

### WARD

City

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### SEX

Female

#### 4 COLOR OR RACE

White

#### 5 Single, Married, Widowed,

or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

#### DATE OF BIRTH (month, day, and year)

11-22-27

#### AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

15

#### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Ind -

#### 10 NAME OF FATHER

Edward Donnelly

#### 11 BIRTHPLACE OF FATHER (city or town)

N. J.

#### 12 MAIDEN NAME OF MOTHER

Bessie Ober

#### 13 BIRTHPLACE OF MOTHER (city or town)

Ind -

Informant (Address)

Records -

Filed

1928

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

March 7 1928

#### 17

I HEREBY CERTIFY, That I attended deceased from Feb 23, 1928, to March 7, 1928.

that I last saw her alive on March 7, 1928, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH\* was as follows:

Tuberculous Meningitis

(duration)

yrs.

mos.

27 ds.

CONTRIBUTORY (Secondary)

Miliary tuberculosis

(duration)

yrs.

mos.

27 ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Positive reaction to tuberculin

(Signed)

Alvan R. ... M. D.

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Carmel ...

#### DATE OF BURIAL

Mar. 8 1928

#### UNDERTAKER

Lilly & Zeller Inc.

#### ADDRESS

403 S. Wolfe St.

E 31385

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31385

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital 10-14* WARD)2-FULL NAME *Mrs Catherine Knolle*(a) RESIDENCE No. *1008 Greenmount Ave* ST.

(Usual place of abode)

Length of residence in city or town where death occurred *46* yrs. — mos. — ds.

WARD

(If non-resident give city or town and State) yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Widow*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Ernest Knolle*DATE OF BIRTH (month, day, and year) *Dec 15 1881*

AGE

Years

Months

Days

If LESS than  
1 day... hrs.  
or... min.*46 yrs.**2**22*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Balt. Md*

10 NAME OF FATHER

*John Raffran*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Balt. Md*

12 MAIDEN NAME OF MOTHER

*Mary Annold*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balt. Md*Informant  
(Address)*Mrs Estelle Kenley*  
*2329 Madison Ave*

Filed

*Geo W Little*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-7-1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*3-2*, 19*28*, to *3-7*, 19*28*.that I last saw him alive on *3-7*, 19*28*and that death occurred, on the date stated above, at *4 P. m.*The CAUSE OF DEATH\* was as follows:  
*Infectious arthritis.*(duration) yrs. *2* mos. — ds.CONTRIBUTORY  
(Secondary)*Brain Abscess and  
respiratory failure*(duration) yrs. mos. *4* ds.18 Where was disease contracted  
if not at place of death?*Don't know*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*

(Signed)

*W. K. Lee*

M. D.

, 19 (Address)

*513 Cathedral St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Chew Cathedral*

20 UNDERTAKER

*Geo W Little*

DATE OF BURIAL

19

ADDRESS

E 31386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 31386

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hosp.* ST. *Agnes* WARD)

2-FULL NAME

*Baby Girl Beckman*

(a) RESIDENCE NO. *3221 Ludo St. City*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *3-7-28*

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Balto*

10 NAME OF FATHER

*Daniel Beckman*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Washington DC*

12 MAIDEN NAME OF MOTHER

*Marck C. King*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto. Md*

Informant

(Address)

*Daniel Beckman 3221 Ludo St. City*

MAR 8 - 1928

*11*

*11*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-7-1928*

17

I HEREBY CERTIFY, That I attended deceased from *3-7-*, 19*28*, to *3-7-*, 19*28*,

that I last saw h*er* alive on *3-7-*, 19*28*

and that death occurred, on the date stated above, at *11 30* p m

The CAUSE OF DEATH\* was as follows:

*Asphyxia neonatorum*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. D. B. Day, M. D.*

, 19 (Address) *St Agnes' Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral Cemetery Mar. 8 1928*

UNDERTAKER

ADDRESS

*Edwin W. Conklin 924 Eager*



31387

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001 ✓  
E 31387  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 515 S. Rose St St. 1-3 Ward)

## 2-FULL NAME

John J. Addicks

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

515 S. Rose St

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

5 ~~Single~~, ~~Married~~, ~~Widowed~~,  
or ~~Divorced~~ (write the word)MaleWhiteInfant5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct 10<sup>th</sup> 1926

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.11626

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workInfant(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Md.

## 10 NAME OF FATHER

George W. Addicks

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Jessie Harrison

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant  
(Address)George J. Addicks  
515 S. Rose St

## 15

Filed

1928JOHN J. ADDICKS  
1-3  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

Mar 6<sup>th</sup> 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 27, 1928, to Mar 6, 1928.that I last saw him alive on Mar 5, 1928.and that death occurred, on the date stated above, at 145 E.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)No

(duration) .....yrs. ....mos. ....ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of NoWas there an autopsy? NoWhat test confirmed diagnosis? Lung smears(Signed) A. J. Smith M. D., 1928 (Address) 3010 Elmwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Baltimore Cem.Mar 8<sup>th</sup> 1928

## 20 UNDERTAKER

ADDRESS

Leo G. Crook1723 Path Pkline

31388

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

5 yrs. 11 mos. 8 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

4 Informant (Address)

5 - 1928

C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 2/22/28, 19 to 3/7/28, 19

that I last saw him alive on 3/7/28, 19

and that death occurred, on the date stated above, at 2:15 m.

The CAUSE OF DEATH\* was as follows:

Acute Appendicitis

CONTRIBUTORY (duration) yrs. mos. 12 ds. Primary Peritonitis (Secondary) (duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/22/28

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Winstead, M. D.

, 19 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31389

## CERTIFICATE OF DEATH.

E 31389

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1234 Union Ave. ST., 13 WARD)2-FULL NAME Raymond E. Parks(a) RESIDENCE NO. 1234 Union Ave. ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) SingleIf married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_DATE OF BIRTH (month, day, and year) Nov. 4-1897AGE Years Months Days If LESS than 1 day.....hrs. or.....min.  
30 4 2

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md.  
(State or country)10 NAME OF FATHER Zephaniah Parks11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Rachel A. Ruby13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant Zephaniah Parks  
(Address) 1234 Union Ave.15 Filed 1928

19

HARRISON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1928

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1927, to March 6, 1928.that I last saw him alive on March 5, 1928.and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH\* was as follows:

Bronchitis(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas J. Cronan, M. D., 19 (Address) 1051 Highland St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Woodlawn

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Horace F. Burgee631 Falls Rd

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31390

## CERTIFICATE OF DEATH.

129 E 31390

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *2706* *Pennsylvania Ave.* *15-54* Ward)

Registered No. ....

2-FULL NAME *William T. Bockstein*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *2706* *Pennsylvania Ave.* Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. *10* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE, *White*5-Single, Married, Widowed, or Divorced, (Write the word) *Married*

6a-If married, widowed, or divorced

HUSBAND of (or) WIFE *Mary C. Bockstein*7-DATE OF BIRTH (month, day and year) *Oct 4, 1858*8-AGE, *69* yrs. *5* mos. *3* ds.

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Shoemaker*(b) General nature of industry, business, or establishment in which employed (or employer) *08*

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), *Balto Md*10-NAME OF FATHER *Frank Bockstein*11-BIRTHPLACE OF FATHER (city or town) (State or Country), *Benny*12-MAIDEN NAME OF MOTHER, *Anna Schuman*13-BIRTHPLACE OF MOTHER (city or town) (State or Country), *Benny*

PARENTS:

14-

(Informant) *Mary C. Bockstein*(Address) *217.66 Pennsylvania Ave*

15-

Filed *1928*

492

HAMPSON JOHN H.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *Nov 7, 1928*I HEREBY CERTIFY, That I attended deceased from *Nov 7* to *Nov 7* 19 *28*that I last saw him alive on *Nov 7* 19 *28*and that death occurred, on the date stated above, at *1:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Coronary Arteriosclerosis of Heart*  
*Coronary Hypertrophy*(Duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *4* yrs. mos. ds.18-Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signature) *W. H. King* M. D.(Address) *600 N. Market St*

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL *Wood Ridge Cem*DATE OF BURIAL, *Nov 9, 1928*20-UNDERTAKER, *Schloman & Son*ADDRESS *1039*

31391

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Balto. General Hospital* WARD)

2-FULL NAME *Charles Dyer*

(a) RESIDENCE NO. *226 N. Wolf*

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. mos.

ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Eliza Dyer*

DATE OF BIRTH (month, day, and year) *2 2 1858*

AGE Years Months Days If LESS than 1 day, hrs. or min. *70 2 2*

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Light House Service*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Washington D.C.*

10 NAME OF FATHER *Elison Dyer*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Virginia*

12 MAIDEN NAME OF MOTHER *Elizabeth Baggett*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Virginia*

14 Informant *Eliza Dyer*

(Address) *226 N. Wolf St.*

15 Filed *1928*, 19 *HAMPSON JONES, JR.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 8 1928*

17

I HEREBY CERTIFY, That I attended deceased from *February 1*, 1928, to *March 8*, 1928.

that I last saw him alive on *March 8*, 1928.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

- 1) *Hypertrophied Prostate*
- 2) *Dysphilia*
- 3) *Arterio-sclerosis*

(duration) *3* yrs. mos. ds.

CONTRIBUTORY *Arterial fibrillation with*

(Secondary)

*cardiac failure* (duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *2/1/28*

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical & Operative*

(Signed) *Paul Scherker*, M. D.

, 19 (Address) *West Balto. General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore Cemetery*

*3/10/28*

20 UNDERTAKER

ADDRESS

*Hughes Jones Inc. 444 N. Bond*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31392

## CERTIFICATE OF DEATH.

31 E 31392

## 1-PLACE OF DEATH

City of BALTIMORE: No. 208 N. Gilmore St., 19-27 Ward)2-FULL NAME George R. Patterson(a) RESIDENCE NO. 208 N. Gilmore St., \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

Cold5 Single, Married, Widowed,  
or Divorced, (write the word)Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 8 - 1902

7 AGE

Years

Months

Days

25228IF LESS than  
1 day.....hrs.  
or.....min.29

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....Laborer(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country)

Baeto

10 NAME OF FATHER

Isaac Patterson

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Md

14

Informant

(Address)

Mary Walker  
208 N. Gilmore St

15

Filed

C. HAMMOND JONES, M. D.  
RCA Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 - 192817 I HEREBY CERTIFY that I took charge of the  
remains described above, held an inquest  
(Inquest, autopsy, or inquiry)  
thereon and from the evidence obtained by such inquest  
and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pulmonary TuberculosisCONTRIBUTORY  
(Secondary)Heart Failure  
(Signed) Thos. B. Horton M. D.  
(Coroner)8-19-28 (Address) Curtis Bay,\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, (2) Whether Acci-  
dental, Suicidal, or Homicidal. (3) If from accident, state the cause.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death:.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Auburn only 3/10/28

20 UNDERTAKER

J. Leow Hall ADDRESS 75-3  
Dolphin

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31393

## CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1313 E Fayette*)2-FULL NAME *Abraham Hall*(Residence in Baltimore: No. *1313 E Fayette*)WARD) *5-8*

St.: yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## SEX.

*Male*

## 4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

## 6-DATE OF BIRTH,

*unknown*, 1 (Month) (Day) (Year)

## 7-AGE,

*54* yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)*Labor*

## 9-BIRTHPLACE, (State or Country),

*Baltimore City*

## 10-NAME OF FATHER,

*Mordua Hall*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Baltimore*

## 12-MAIDEN NAME OF MOTHER

*Hennetta Huston*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Baltimore*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rebecca Colburn*(Address) *1313 E Fayette St*

## 15-

Filed *C. HAMPTON JONES, M. D.*  
*1828* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 6, 1928*  
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Feb 24* 1928, to *March 6* 1928, that I saw him alive on *March 6* 1928, and that death occurred, on the date stated above, at *10:35* a.m.

The CAUSE OF DEATH\* was as follows:

*Acute Parenchymatous Nephritis*

## CONTRIBUTORY (Secondary)

*Pulmonary Adenoma*  
(Duration) yrs. mos. ds. *10*  
(Signed) *R. J. Young* M. D.  
*3/7*, 1928. (Address) *1313 E Fayette St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Laural Ave*

## DATE OF BURIAL,

*March 8, 1928*

## 20-UNDERTAKER

*John W. Henderson & Monument*

## ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31394

## CERTIFICATE OF DEATH.

75-001  
E 31394  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 N Bond

ST.: 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Elliott

(Residence in Baltimore: No. 610 N Bond

St.: 40 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE. Colored	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow
----------------	-----------------------------	--

6-DATE OF BIRTH, 1908  
(Month) (Day) (Year)

7-AGE, 45 yrs., mos. ds.  
If LESS than 1 day, hrs. or min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Labor  
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE,  
(State or Country), N. Carolina

10-NAME OF FATHER, Henry Elliott  
11-BIRTHPLACE OF FATHER, N. Carolina  
12-MAIDEN NAME OF MOTHER, Emily Elliott  
13-BIRTHPLACE OF MOTHER, N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Lewis

(Address) 610 N Bond St

15-

Filed..... 191

C. HAMPSON JONES, Registrar

- 1928

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6, 1908.  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 2, 1908 to March 6, 1908, that I saw him alive on March 6, 1908, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH\* was as follows:

17-CAUSE OF DEATH, Intermittent  
(Duration) yrs. mos. ds. 4

CONTRIBUTORY (Secondary) Intermittent  
(Duration) yrs. mos. ds. 1

(Signed) J. B. Bennett, M. D.  
March 6, 1908 (Address) 508 S. E. 1st St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. do. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Calvary Cem

DATE OF BURIAL, March 9, 1908

20-UNDERTAKER, John W. Henderson

ADDRESS 1502 E. Myerment

31395

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31395

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 15 WARD 13)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Eleanor Hammond(a) RESIDENCE NO. 4006 Benhill Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

? yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White ?

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address)

15 1928

C. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 15, 1924, to Mar 6, 1928that I last saw him alive on Mar 6, 1928and that death occurred, on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sub.(Signed) C. Hammond Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London ParkMar 9 1928Wm Cook 502 E North



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31396

E 31396

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 26-37 ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Andrew Churchill(a) RESIDENCE NO. 4711 Eastern Ave.

(Usual place of abode)

## WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

Non long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

malewhitemarriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.65

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of worknone(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

Austria

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant

(Address)

Filed

C. HARRISON, JR., R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 31 7 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 7, 1928, to Mar. 7, 1928.that I last saw him alive on Mar. 7, 1928and that death occurred, on the date stated above, at 2:20 P. M.

The CAUSE OF DEATH\* was as follows:

myocarditis chronic & acute  
arteriosclerosis  
hypertension(duration) yrs. 2 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. HARRISON, JR., M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVING

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Secord Heart May Mar 10 1928  
Wm Cook Bar E North



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31397

E 31397

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *The Charles apt 5* *8333 N. Charles* ST. *12-49* WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

*Alveta Bangly Grindall*

### (a) RESIDENCE NO.

(Usual place of abode) *The Charles apt 5* *8333 N. Charles* ST. *12-49* WARD  
Length of residence in city or town where death occurred *71* yrs. *3* mos. *15* ds.

### ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

If married, widowed, or divorced

HUSBAND of *Dr Charles S. Grindall (deceased)*  
(or) WIFE of

DATE OF BIRTH (month, day, and year) *Nov. 21<sup>st</sup> 1856*

AGE *71* Years *3* Months *16* Days *15* If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*

10 NAME OF FATHER *Wash Wash Bangly*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore*  
(State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Mary Jane Torrey*

13 BIRTHPLACE OF MOTHER (city or town) *Frederick*  
(State or country) *Maryland*

4 Informant *Mrs. Harry Baker*  
(Address) *Catonville, Md.*

5 *C. HAMPTON JONES, M. D.*  
Registrar *1928*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 7<sup>th</sup> 1928*

17 I HEREBY CERTIFY, That I attended deceased from *November 2<sup>nd</sup> 1926* to *March 7<sup>th</sup> 1928*  
that I last saw him alive on *March 7<sup>th</sup> 1928*

and that death occurred, on the date stated above, at *3:10 p. m.*

The CAUSE OF DEATH\* was as follows:

*Angina Pectoris*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Edgar J. Perkins M.D.*

, 19 (Address) *1 West Franklin St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral Cem*

*3-9 1928*

20 UNDERTAKER

ADDRESS

*Henry W. Jenkins Sons Co*

*orchard me Cuckoo.*

31398

HEALTH DEPARTMENT—CITY OF BALTIMORE

31398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 E.Oliver St.

ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Pieper

(a) RESIDENCE NO. 1711 E.Oliver St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

If married, widowed, or divorced

HUSBAND of (or) WIFE of Pieper

DATE OF BIRTH (month, day, and year) Sept. 20/1849

AGE Years Months Days 78 5 18 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Saloon Keeper

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Pieper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. H. Myers (Address) 1711 E.Oliver St.

15 1928 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7th. 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1928, to March 7, 1928, that I last saw him alive on March 7, 1928, and that death occurred, on the date stated above, at 7.10 PM.

The CAUSE OF DEATH\* was as follows:

Chronic Myocardial Degeneration

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical (Signed) John S. Fisher, M. D.

3/8, 1928 (Address) 4 E. Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31399

E 31399

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2614 Harford Ave ST. 7-12 WARD)

### 2-FULL NAME

Emma F. Storck

(a) RESIDENCE NO. 2303 Ashland Ave ST. 7-12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Bernhard F. Storck

DATE OF BIRTH (month, day, and year) Aug 15/65

AGE Years 62 Months 6 Days 23 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

BIRTHPLACE (city or town) City (State or country)

10 NAME OF FATHER Chas. Myers

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Sarah J.

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Bernhard Myers (Address) 2614 Harford Ave

15 Filed 1328 24 1928 HAMPSON RECORDS

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7 1928

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1928, to March 7, 1928.

that I last saw him alive on March 7, 1928, and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH\* was as follows:

Influenza

(duration) yrs. 0 mos. 7 ds.

CONTRIBUTORY Broncho-Pneumonia (Secondary)

(duration) yrs. 0 mos. 2 ds.

18 Where was disease contracted at place of death if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical (Signed) John S. Farley M. D.

3/8, 1928 (Address) 4 E. Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Bernard

DATE OF BURIAL

8/11 1928

20 UNDERTAKER

Philip Herwig

ADDRESS 2016 Orleans

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31400

## CERTIFICATE OF DEATH.

E 31400

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospitals St. 6-10 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. T. Burns(a) RESIDENCE NO. 2333 McElderry St. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence R. Burns

6 DATE OF BIRTH (month, day, and year) Dec. 10th. 1892

7 AGE Years 35 Months 2 Days 27 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York  
(State or country)

10 NAME OF FATHER Burns

11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)

14 Informant Florence R. Burns  
(Address) 2333 McElderry St.

15 Filed 1928 16 HAMPTON JONES Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6/28<sup>92</sup>

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

hereon and from the evidence obtained by said Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Int Nephritis

CONTRIBUTORY (Secondary)

Q. Austin (duration) yrs. mos. ds. 7  
Mar 9/28 G. E. Blades (duration) yrs. mos. ds. 1  
Signed (Coroner) M. D. 143701 3rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence: \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem,

Date of Burial

3/9/28<sup>92</sup>

20 UNDERTAKER

Philip HerwigADDRESS 2000  
William St.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31401

## CERTIFICATE OF DEATH.

90 E 31401

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1627 E. Federal* ST. *8-17* WARD)

### 2-FULL NAME

*Eva K. Otto*

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### (a) RESIDENCE No.

*1627 E. Federal*

ST. *8-17* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *79* yrs. *5* mos. *14* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White*

*Widowed*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Andrew Otto*

7 DATE OF BIRTH (month, day, and year)

*Sept 22/48*

AGE

Years

Months

Days

If less than 1 day, hrs. or min.

*79*

*5*

*14*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*City*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ger.*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ger.*

14

Informant (Address)

*Chas. A. Otto 1524 N. Bond St*

15

Filed *1928*, 19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar. 6 1928*

17

I HEREBY CERTIFY That I attended deceased from *March 1 1928* to *March 6 1928*, that I last saw her alive on *March 5 1928*, and that death occurred, on the date stated above, at *11:15 A.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic myocarditis*

(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical*

(Signed) *R. L. Gordy*, M. D.

*3-7, 1928* (Address) *4218 Hayford Road*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Baltimore Cem.*

DATE OF BURIAL

*Mar 9 1928*

20 UNDERTAKER

*Philip Herwig*

ADDRESS *2016 Orleans St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31402

## CERTIFICATE OF DEATH.

148 E 31402

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1214 W North St. 13-59 Ward)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Caples

(a) RESIDENCE NO. 1214 W North St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of William Caples (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 4th 1908

7 AGE Years 19 Months 7 Days 4 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. Co. Md. (State or country)

10 NAME OF FATHER Howard Nathan

11 BIRTHPLACE OF FATHER (city or town) Balt Co Md. (State or country)

12 MAIDEN NAME OF MOTHER Ma Duane

13 BIRTHPLACE OF MOTHER (city or town) Balt Co Md. (State or country)

14 Informant Mrs Caples (Address) 2206 Eutan Pl.

1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8th 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 8th 1928, to Mar 8th 1928, that I last saw him alive on Mar 8, 1928, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:

Uremia in pregnancy (Comp.)

(duration) ..... yrs. .... mos. .... ds. 8 hrs.

CONTRIBUTORY (Secondary) High pressure (Comp.) &amp; failure of heart action (duration) ..... yrs. .... mos. .... ds. 2 hrs.

15 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Micro

(Signed) J. H. Smith, M. D.

Address 1605 W North St

\*State the Disease, Cause of death, from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Ariston Ridge Cemetery Mar 10 1928

20 UNDERTAKER

ADDRESS

Harry H. Witzke 1531 W. Lombard St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31403

## CERTIFICATE OF DEATH

E 31403

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *mt. St. Agnes, mt. Washington*)

## 2-FULL NAME

*Sister Mary Raymond Lavin*

## (a) RESIDENCE NO.

*mt. St. Agnes, mt. Washington Md.*

(Usual place of abode)

Length of residence in city or town where death occurred *31* yrs. — mos. — ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? *Yrs.* *mos.* *ds.*

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 Color or Race

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Sept. 29, 1870*

## 7 AGE

*57* YearsMonths *5*Days *9*IF LESS than  
1 day — hrs.  
or — min..*58*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Religious*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Savannah**Georgia*

## 10 NAME OF FATHER

*Michael Lavin*11 BIRTHPLACE OF FATHER (City or town)  
(State or country)*Ireland*

## 12 MAIDEN NAME OF MOTHER

*Bridget Lavin*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Ireland*

## 14

Informant  
(Address)*Rev. Mother Carmelita  
mt St. Agnes.*15 *1928**FRANCIS JONES, M. D.*

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 8<sup>th</sup> 1928*

## 17

I HEREBY CERTIFY. That I attended deceased *on*  
*March 8, 1928, to*that I last saw her alive on *March 8, 1928,*and that death occurred, on the date stated above, at *1245 PM*

The CAUSE OF DEATH\* was as follows:

*Arterial Hypertension  
Cerebral Hemorrhage*CONTRIBUTORY  
(Secondary)(duration) *3 hrs.* yrs. *mos.* *ds.*(duration) *2 hrs.* yrs. *mos.* *ds.*

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *R. Raymond Peters, M. D.*19 *1908* (Address) *W. Lexington St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*mt St Agnes Cemetery Ground**March 10 1928*

## 20 UNDERTAKER

*Ray Jenkins & Co*

ADDRESS

*Calverton  
No. 1000*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31404

## CERTIFICATE OF DEATH.

99-E 31404

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1142 Carrie, St. 34 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1142 Carrie

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Robinson6 DATE OF BIRTH (month, day, and year) July 8, 18967 AGE Years 31 Months 7 Days 29 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia10 NAME OF FATHER John Robinson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

PARENTS

14 Informant (Address) John Robinson  
1142 Carrie15 Filed G. HAMMOND JONES Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7, 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chr Bronchitis

CONTRIBUTORY (Secondary)

Aspiration (duration) 14 mos. 14 ds.  
Mar 7, 1928 (Signed) G. C. Jones (Coroner) M. D.143 101 Street (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

Cruxur. Condy Mar 9, 1928  
Stoddell Hopper 300 S. Calhoun

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31405

## CERTIFICATE OF DEATH.

E 31405

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 15 Narimay Ct St., 2-4 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 15 Narimay Ct St., 2-4 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

1928

C. H. HARRISON JONES, JR.,  
Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 192817 I HEREBY CERTIFY that I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, autopsy or inquiry.) and that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Paralysis R. SideCONTRIBUTORY  
(Secondary)(Signed) W. C. Blades M. D.(Address) 14318 Broadway\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Wendell H. Hopper 300 S. E. 11



31406

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

31 E 31406

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1012 N. Stricker* St. *16-22* Ward)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Thomas Hillery*(a) Residence No. *1012 N. Stricker St.* St. .... Ward ....  
(Usual place of abode)Length of residence in city or town where death occurred *29* yrs. .... mos. .... ds. How long in U. S., if of foreign birth? yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*Colored*5-Status, Married, Widowed, or Divorced, (Write the word.) *Widowed*

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) *unknown 1899*

7-AGE.

*29*

If LESS than 1 day,

... hrs. or ... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

*Musician*

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), *Balt.*10-NAME OF FATHER, *Thomas Hillery*11-BIRTHPLACE OF FATHER (city or town) (State or Country), *md*12-MAIDEN NAME OF MOTHER, *Rebecca Clark*13-BIRTHPLACE OF MOTHER (city or town) (State or Country), *md*14- (Informant) *Rebecca Hillery*  
(Address) *1012 N. Stricker St.*15- *1928* *BARBARA JONES, II.*

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *March 5-1928*17- I HEREBY CERTIFY, That I attended deceased from *March 3rd*, 1928, to *March 6th*, 1928.that I last saw him alive on *March 6th*, 1928.and that death occurred, on the date stated above, at *8:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Polar Pneumonia*(Duration) .... yrs. .... mos. .... ds. *3*CONTRIBUTORY *Pulmonary Tuberculosis*  
(Secondary) *(Hunting)*(Duration) *2* yrs. .... mos. .... ds.18-Where was disease contracted *at place of death*  
If not at place of death?Did an operation precede death? *No* Date of .....Was there an autopsy? *No*What test confirmed diagnosis? *Clinical findings*(Signed) *Samuel Fargo* M. D., 19 (Address) *2937 N. Calvert St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, *mt Zion* DATE OF BURIAL, *March 9, 1928*20-UNDERTAKER, *John H. Toadrum* ADDRESS *1037**and Hill*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31407

## CERTIFICATE OF DEATH.

129 E 31407  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 N. Calumpton St. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Albert Thomas Yeager.

## (a) RESIDENCE NO.

1401 N. Calumpton St.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Eliza Yeager.

## 6 DATE OF BIRTH (month, day, and year)

March 10, 1851

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

11

27

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Retired

## (b) General nature of industry, business, or establishment in which employed (or employer)

Conductor

## (c) Name of employer

B &amp; O R. R.

## 9 BIRTHPLACE (city or town) (State or country)

Philadelphia

Penn.

## 10 NAME OF FATHER

Unknown.

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Penn.

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Penn.

## 14

Informant (Address)

Miss Sophia Yeager  
1401 N. Calumpton

## 15

Filed

MAR 9 - 1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1928, to March 8, 1928,

that I last saw him alive on March 7, 1928,

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Uraemia  
Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed)

3/8, 1928 (Address) 2877 1/2 Madison St. M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Baltimore

## 20 UNDERTAKER

W. H. Cook

## DATE OF BURIAL

3/10 1928

## ADDRESS

502 E. North Ave

E 31408

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001  
E 31408

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *404 Edwards Ave.* St. *27-48* Ward)

Registered No. ....

## 2-FULL NAME.....

*Mrs. Mary A. Holzer*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) Residence No. ....

*404 Edwards Ave.*

St. ....

Ward. ....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*3* yrs.*8* mos.

ds.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*F*

4-COLOR OR RACE,

*W.*5-Single, Married, Widowed, or Divorced, (Write the word.) *Widow*

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

*Anthony Holzer*

6-DATE OF BIRTH (month, day and year)

*March 25 1854*

7-AGE,

*73* yrs.*11* mos.*13* ds.

If LESS than 1 day.

...hrs. or...min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

*House-work*

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country).

*Cumberland Md.*

10-NAME OF FATHER,

*Edward Holzer*

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

*Belair*

12-MAIDEN NAME OF MOTHER,

*Mary Beban*

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

*Belair*

11-

(Informant)

*George L. Holzer*

(Address)

*1925 Bay St. Wash. D.C.*

15-

AR 9 - 1928

HARRISON, JAMES, M. D. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

*March 8/28*

17- I HEREBY CERTIFY, That I attended deceased from

*Feb. 25*, 19*28*, to *March 8*, 19*28*.that I last saw her alive on *March 8*, 19*28*.and that death occurred, on the date stated above, at *6:30* p.m.

The CAUSE OF DEATH\* was as follows:

*Branchio-Pneumonia  
Acute Cardiac Dilatation*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of .....

Was there an autopsy? *No*What test confirmed diagnosis? *Smear*(Signed) *John H. Holzer*, M. D., 19 (Address) *704 York Road*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cumberland and Allegheny Co. Md. Mar 9th 1928*

20-BURIAL

ADDRESS

*Belair Ave. 1723 W. Lafayette Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31409

## CERTIFICATE OF DEATH.

90 E 31409

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2423 Guilford Ave ST. 17-50 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

63

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 12, 1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

6

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

William G. McComas

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Catherine Cunningham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

Douglas McComas

(Address)

2423 Guilford Ave

15

Filed

MAR 3 - 1928 HARRISON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 8 1928

17

HEREBY CERTIFY That I attended deceased from

about Mar 7, 1928, to Mar 8, 1928

that I last saw him alive on Mar 7, 1928

and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH was as follows:

Organic Heart Disease (Mitral Insufficiency)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed)

J. E. Ebaugh, M. D.

(Address)

740 St. Paul Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wood Ridge

20 UNDERTAKER

Joseph S. Sizer

March 9, 1928

ADDRESS

1600 W. North Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31410

## CERTIFICATE OF DEATH.

31✓

E 31410

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1326 Aisquith Street ST. 9-18 WARD)

2-FULL NAME Agnes Rita Brady

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1326 Aisquith Street ST. WARD \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1910

7 AGE Years 17 Months 4 Days 1 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)

10 NAME OF FATHER Edward Brady

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.  
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Banahan

13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)

14 Informant Mrs. Agnes Brady  
(Address) 1326 Aisquith St.

15 MAR 9 - 1928 HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7 19 28

17 I HEREBY CERTIFY, That I attended deceased from July, 19 28, to March 7, 19 28.  
that I last saw her alive on March 7, 19 28,  
and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH\* was as follows:  
Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY none  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? Xray  
(Signed) E. T. Bouckee, M. D.

3-8, 1928 (Address) 2104 St. Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral

DATE OF BURIAL

Mar. 10, 28.  
ADDRESS

UNDERTAKER

Rita Weidfeld 914 Greenmount Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31411

## CERTIFICATE OF DEATH.

74-001  
REGISTERED NO.

E 31411

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sister of the Po 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Catherine Sharkey

## (a) RESIDENCE NO.

Preston + Valley

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 Color or Race

W

## 5 Single, Married, Widowed, or Divorced, (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

June 18, 1867

## 7 AGE

Years

Months

Days

60820

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Ireland

## 10 NAME OF FATHER

Thomas Sharkey

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Catherine Leary

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

## 14

Informant (Address)

Little Sister of the Po  
Preston + Valley St

## 15

Filed..... 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19 28March 8<sup>th</sup>

## 17

I HEREBY CERTIFY, That I attended deceased from

3/7....., 1928, to Mar 8, 1928,that I last saw him alive on Mar 6, 1928,and that death occurred, on the date stated above, at a.....m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage(duration).....yrs. ....mos. 1 ds.

## CONTRIBUTORY

(Secondary)

Ordinary lungs(duration).....yrs. ....mos. 2 ds.

## 18 Where was disease contracted

If not at place of death

Did an operation precede death?.....Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Mansworth, M. D.3/8, 1928 (Address) 914 E. Biddle

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Cathedral

ADDRESS

## 20 UNDERTAKER

W. A. Mansworth, 914 E. Biddle Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 31412**

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

90 ✓  
**E 31412**  
REGISTERED NO.City of BALTIMORE: (No. Little Sisters of the Poor 10-14 Ward)

2-FULL NAME

Elmer Bradley

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Preston + Valley

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 Color or Race

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 22, 1845

7 AGE

Years

82

Months

7

Day

15

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

10 NAME OF FATHER

Heam. Walters

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Sarah Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Little Sisters of the Poor  
Preston + Valley St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

17

I HEREBY CERTIFY, That I attended deceased from Mar 7, 1928, to May 7, 1928, that I last saw h... alive on Mar 6, 1928, and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH\* was as follows:

Chronic InduratedUnknown (duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death?.....Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Jones, M. D.  
28, 1928 (Address) 914 E. Biddle

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial  
Mar 9 1928  
ADDRESS

UNDERTAKER

London Park  
Rita M. M. M. 914 Greenmount Ave

MAR 9 - 1928

HARRISON JONES, M. D.

Registrar

E 31413

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001

E 31413

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 19-27 Ward)2-FULL NAME Leroy Gross(a) RESIDENCE NO. 1621 Sarah Ann

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)

Male

Negro

Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 12, 1927

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

5

25

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto. Md.

10 NAME OF FATHER

Roosevelt Maxwell

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Gladys Gross

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto. Md.

14

Informant Gladys Gross

(Address) 1621 Sarah Ann St.

15

FILE 1928

C. H. JONES, M. D.

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

(If non-resident give city or town and State)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 7

1928

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
inquiry find that said deceased came to his death  
(Inquest, au-  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Lobar Pneumonia

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)(Signed) Edgar J. Zeller M. D.

(Coroner)

3/7/28 (Address) 2739 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place  
of death.....yrs.....mos.....ds. In the  
State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Date of Burial

Mount Lion

DERTAKER

Joseph A. Lively

3-9-28

ADDRESS  
409 Mount  
street

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31414

E 31414

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL ST. 8-17 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alonzo Anderson(a) RESIDENCE NO. 1642 Ellsworth St

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 5 yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

February 1899

7 AGE

31

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

John Anderson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Zahmie Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Academy Blunk Rouse

15

Filed

1928

C. H. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb-10, 1928, to March 8, 1928.

that I last saw him alive on March 8, 1928,

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia - Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) I. B. Smith, M. D.

3-8, 1928 (Address) Johns Hopkins

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Meacham VA

DATE OF BURIAL

Mar 9, 1928

UNDERTAKER

Mrs. R. G. Elliott

ADDRESS

1725 Ashland

E 31415

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31415

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 Willax Ave., Raspeburg ST., 26th WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert J. Moeller

(a) RESIDENCE NO. 20 Willax Ave., Raspeburg ST., 26th WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Madeline A. Moeller

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1898.

7 AGE Years Months Days 30 0 8 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-binder

(b) General nature of industry, business, or establishment in which employed (or employer) Day Printing Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Julius Moeller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Keilbar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Madeline A. Moeller (Address) 20 Willax Ave., Raspeburg, Md.

15 Filed 1926. HAMPSON JONES, II. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 19 28

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1927, 19 to March 7, 19 28 that I last saw him alive on March 7, 19 28 and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. L. Wilkinson, M. D.

3/7, 19 28 (Address) 5715 Belair Rd., Raspeburg,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Parkwood Cemetery

March 10, 1928

20 UNDERTAKER

ADDRESS

Frederick Lassabm Sons

Fullerton

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31416

31416

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3008 Harrison Ave ST. 15-61 WARD)2-FULL NAME Charles P. Loring(a) RESIDENCE NO. 3008 Harrison Ave. ST., \_\_\_\_\_ WARD Auburn Maine  
(Usual place of abode)Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel M. Loring6 DATE OF BIRTH (month, day, and year) April 13-18887 AGE Years 45 Months 10 Days 25 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Treasurer(b) General nature of industry, business, or establishment in which employed (or employer) Bushman, Pollitt & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Auburn, Maine  
(State or country)10 NAME OF FATHER J. N. Loring11 BIRTHPLACE OF FATHER (city or town) Maine  
(State or country)12 MAIDEN NAME OF MOTHER Carrie Drake13 BIRTHPLACE OF MOTHER (city or town) Maine  
(State or country)14 Informant Mrs. Ethel M. Loring  
(Address) 209 Winter St. Auburn15 Filed 1928 Registrar [Signature]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8-192817 I HEREBY CERTIFY, That I attended deceased from Feb 29, 1928, to March 8, 1928, that I last saw him alive on March 8, 1928, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds.  
CONTRIBUTORY (Secondary) Quadruple ulcer(duration) \_\_\_\_\_ yrs. 3 mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis?

(Signed) A. J. Davis, M. D.(Address) 800 W 33rd Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Auburn, Maine DATE OF BURIAL March 9 192820 UNDERTAKER Horace F. Burgee ADDRESS 3634 Falls Road



E 31417

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31417

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 425 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

(a) RESIDENCE NO. 230 Park Ave ST. 425 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 30 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male Chinese Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 BALTIMORE CITY HOSPITALS

Informant (Address) Records

15 Filed 1928

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/1928

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1928, to March 7, 1928.

that I last saw him live on March 7, 1928,

and that death occurred, on the date stated above, at 12:15 A. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis chronic & acute atherosclerosis. Hypertension

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Sub

(Signed) C. J. Overman Surgeon M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery March 10 1928

20 UNDERTAKER

ADDRESS

Onufull & Sons

E 31418

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Sinai Hospital

CITY OF BALTIMORE: (No.

ST. 3-5 WARD)

2-FULL NAME

Mrs Mary Shulack

(a) RESIDENCE NO.

128 South Essex

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

23 yrs. mos. ds.

How long in U. S., if of foreign birth? 23 yrs. mos. ds.

REGISTERED NO.

E 31418

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a if married, widowed, or divorced HUSBAND or (or) WIFE of

Morris Shulack

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Velvel Fein

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Morris Shulack  
128 South Essex

15

Filed

1928

C. HAMMON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/9 1928

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1928, to March 9, 1928,

that I last saw him alive on March 9, 1928

and that death occurred, on the date stated above, at 6:30 AM

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Failure

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Diabetes mellitus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of 3/9

Was there an autopsy?

What test confirmed diagnosis?

Physical signs

(Signed)

Milton Sherry

M. D.

, 19 (Address)

Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

Rehman Chasdale

3/9 1928

20 UNDERTAKER

ADDRESS

Jack Lewis 1439

5th Ave

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 31419

## CERTIFICATE OF DEATH

117 E 31419

1-PLACE OF DEATH

Colonial Hospital

REGISTERED NO.

City of BALTIMORE: (No.

1122 N. Mount St. 70-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harry Ansel

(a) RESIDENCE NO.

339 S. Smallwood

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs.

mos.

ds.

How long in U. S. if of foreign birth? 2 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie Ansel

6 DATE OF BIRTH (month, day, and year)

March 6 1898

7 AGE

Years

Months

Days

IF LESS than 1 day...hra. or...min..

30 yrs

0

1

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Fire Dept.

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Samuel Ansel

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Anna [unclear]

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

Annie Ansel  
339 S. Smallwood St.

15

Filed 1928

C. H.

J. H.

J. H.

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J. H.

J. H.

J. H.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Schreiner Road

Date of Burial

3/9 1928

20 UNDERTAKER

Jack Lewis 1439 [unclear]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

March, 7

17

I HEREBY CERTIFY, That I attended deceased from

March 3, 1928, to March 7, 1928,

that I last saw him alive on March 7, 1928,

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Acute appendicitis

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY

(Secondary)

Paralytic ileus  
Suppurative Peritonitis  
Bacterial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of March 3

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) J. H. [unclear] M. D.

19 (Address) Colonial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31420

## CERTIFICATE OF DEATH

REGISTERED NO.

E 31420

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1303 Holbrook St. 9-18 Ward)

## 2-FULL NAME

Elizabeth F. Rohe

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1303 Holbrook

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. 5 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year)

June 3<sup>rd</sup> 1927

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

9 5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Home

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Albert J. Rohe

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Elizabeth F. Rowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Mr. Albert J. Rohe  
1303 Holbrook St.

MAR 9 - 1928

HARRISON JONES, JR.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28March 8<sup>th</sup>

17

I HEREBY CERTIFY, That I attended deceased from

Mar 2, 1928, to Mar 8, 1928that I last saw her alive on Mar 8, 1928and that death occurred, on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH\* was as follows:

Cardiac failure resulting from Broncho pneumonia10 days (duration)

yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

CONTRIBUTORY (Secondary)

2 weeks (duration)

yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

18 Where was disease contracted 1303 Holbrook

If not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Physical findings of examination

(Signed)

. 19

(Address)

J. M. Macintosh, M. D.  
6911 Harford Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Joseph's CemeteryFullertonMarch 9, 1928

20 UNDERTAKER

Henry HowellDon1301 E. Eager St.

very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31421

## CERTIFICATE OF DEATH.

X 49 E 31421

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 305-E-25 ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Annie Schultze Dowell(a) RESIDENCE No. 305-E-25 ST.

(Usual place of abode)

ST.

WARD Prince Frederick-Md.Length of residence in city or town where death occurred 0 yrs. 6 mos. 0 ds.Now long in U. S., if of foreign birth? 76 yrs. 5 mos. 1 ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single6 DATE OF BIRTH (month, day, and year) October 7-1851

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 76 5 1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) (State or country) Prince Frederick Maryland10 NAME OF FATHER George Dowell11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince Frederick Maryland12 MAIDEN NAME OF MOTHER Mary E. Shemwell13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Frederick Maryland

14

Informant (Address) Mrs. Rene Hayes (niece)  
305-E-25 St. City

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Filed

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19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Prince Frederick-Md. Mon 10/19/28  
Stewart & Son, Inc. Balt.



31422

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31422

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND or  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

1928

JAMES J. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 18, 1928, to March 8, 1928,  
that I last saw her alive on March 8, 1928,  
and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic.

Hypertension

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Pulmonary edema  
4 hrs (duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical &amp; Laboratory Exam.

(Signed) Frank K. Karlov Morris, M. D.

, 19 (Address) Union Memorial Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31423

## CERTIFICATE OF DEATH.

90 E 31423

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 112811 Parolova 18-16 Ward)

2-FULL NAME Lucy Fortune

(a) RESIDENCE NO. 112 P.M. Parole St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *Col.* 5 Single, Married, Widowed,  
or Divorced, (write the word) *Wid.*

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	7			

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work, *Landrace*

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....*La*  
(State or country)

10 NAME OF FATHER *Mr. B.*

II BIRTHPLACE OF FATHER (city or town) .....  
(State or country) *Ill.*

12 MAIDEN NAME OF MOTHER *L. L.*

13 BIRTHPLACE OF MOTHER (city or town) .....  
(State or country) *Chickasaw*

14 Informant R. L. Fortune  
(Address) 1125 W. Parkside

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17  
I HEREBY CERTIFY, That I attended deceased from  
*Feb 25* *1920*, to *March 6*, 19 *20*,  
that I last saw him alive on *March 5*, 19 *20*,  
and that death occurred, on the date stated above, at *4 P.M.*

The CAUSE OF DEATH\* was as follows:

Argue & Heor

**CONTRIBUTORY**  
(Secondary)

(duration) ..... yrs. .... mos. .... ds.

(duration) .....yrs. ....mos. ....ds

18 Where was disease contracted

**If not at place of death?**

Did an operation precede death? 26 Date of 22

**Was there an autopsy?**

What test confirmed diagnosis: 11

(Signed) \_\_\_\_\_ M. D.  
\_\_\_\_\_, 19 \_\_\_\_ (Address) \_\_\_\_\_

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Laurel Cemetery May 9 192

## 20 UNDERTAKER

Virginia I Brooks 14637, Care

**very important. See instructions on back of certificate.**

18 Filed **1928** C. HANSON, JONES, 12  
Registrars

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31424

## CERTIFICATE OF DEATH.

E 31424

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 543 Lawrence St. 17-24 Ward)2-FULL NAME Leon Davis(a) RESIDENCE NO. 543 Lawrence St. 17-24 WardLength of residence in city or town where death occurred 20 yrs.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 44 4 Color or Race C 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19087 AGE Years 20 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Beelmann

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind  
(State or country)10 NAME OF FATHER Henry Davis11 BIRTHPLACE OF FATHER (city or town) Ind  
(State or country)12 MAIDEN NAME OF MOTHER Missie Williams13 BIRTHPLACE OF MOTHER (city or town) Ind  
(State or country)14 Informant Teacher  
(Address) 543 Lawrence St15 Filed..... 19 28 JOHN M. JONES, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/2817 I HEREBY CERTIFY, That I attended deceased from 9/15/27 to 3/7/28, 19 28, that I last saw him alive on 3/7/28, 19 28, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH was as follows:

Pulmonary I-B-CONTRIBUTORY (Secondary) 7 yrs. 7 mos. 7 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death?..... Date of.....

Was there an autopsy?

What test confirmed diagnosis?.....  
(Signed) J. M. Jones, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial 3/10/2820 UNDERTAKER Mrs. Geo. R. HollandADDRESS 631 Druid Hill Ave

Very important. See instructions on back of certificates.

E 31425 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31425

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 8-13 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs.

6 mos.

16 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

Gretchen Wiseman

6 DATE OF BIRTH (month, day, and year)

Aug 21, 1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

6

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Lickster

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Wiseman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Baltimore City, Md.

15

MAR 9 - 1928

W. J. JONES, II, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-7-1928

17

I HEREBY CERTIFY, That I attended deceased from

2-23-1928 to 3-7-1928

that I last saw him alive on

3-6-1928

and that death occurred, on the date stated above, at 7:10 A. M.

The CAUSE OF DEATH was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Alcoholic Psychosis Paranoiac type

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: Harry H. Downie, M.D.

(Address) Baltimore City, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore County, Md.

Mar. 10, 1928

UNDERTAKER

ADDRESS

William E. Schaeffer 1816 Monument



E 31426 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *805 Vincent St.* ST., *16-77* WARD)2-FULL NAME *Daisy Thomas*(a) RESIDENCE NO. *805 N. Vincent* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female*4 COLOR OR RACE *colored*5 Single, Married, Widowed, or Divorced, (write the word) *widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *William M. Thomas*6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *44*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *md.*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *unknown md.*12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address) *Alice Young 247 Marlborough ave*

15

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/7 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar. 4 1928* to *Mar. 7 1928*, that I last saw her alive on *Mar. 6 1928*, and that death occurred, on the date stated above, at *6:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*CONTRIBUTORY (Secondary) *Cardiac decompensation* (duration) yrs. mo. *4* ds.18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical signs*(Signed) *John W. Saines* M. D.(Address) *1335 Penna. Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*mt. Zion cemetery**3/9/ 1928*

UNDERTAKER

ADDRESS *322**Stella R. Williams**W. Schwab*



E 31427

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Registered No. 100-001 E 31427

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1011 W. Saratoga St., 18-76 Ward)

2-FULL NAME James Sumnerille

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1011 W. Saratoga St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, m

1-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 9-2-26

7-AGE, 6 yrs. 4 mos. 26 ds.

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town), (State or Country), Balto. Md.

10-NAME OF FATHER, Wm. Sumnerille

11-BIRTHPLACE OF FATHER (city or town), (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Emma Henson

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Denton, Md.

14- (Informant) Emma Sumnerille (Address) 1011 W. Saratoga St.

15-

MAR 9 - 1928 HARRISON JONES, M. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3/7/28

17- I HEREBY CERTIFY, That I attended deceased from 3-6-1928, to 3-7-1928, that I last saw him live on 3-7-1928, and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. ds. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of.

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Maceo Williams, M. D.

3-8, 1928 (Address) 1830 Madison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, 3/9/28

20-UNDERTAKER, Mrs. Helen R. Williams

ADDRESS 322 N. Schroeder St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31428

E 31428

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2900 Dillion

St. 1-1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

JOHN KACALA,

## (a) RESIDENCE NO.

2900 Dillion

(Usual place of abode)

St. Ward

Length of residence in city or town where death occurred 27 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? 27 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Kacala,

## 6 DATE OF BIRTH (month, day, and year)

Unknown,

## 7 AGE

Years

Months

Days

50

IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grian trimer,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Austria,

Poland,

## 10 NAME OF FATHER

Vincent Kacala,

## 11 BIRTHPLACE OF FATHER (City or town) (State or country)

Austria Poland,

## 12 MAIDEN NAME OF MOTHER

Julia

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria Poland,

## 14

Informant (Address)

2900 Dillion Street

## 15

File

C. HANSON JONES, M.

P.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 7

19 28

## 17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1928, to April 7, 1928, that I last saw him alive on April 7, 1928, and that death occurred, on the date stated above, at 6:40 p.m.

The CAUSE OF DEATH\* was as follows:

Cancer of Stomach

(duration) 1 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

General Cachexia

(duration) 1 yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. Valentini, M. D.

(Address)

14 50 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Stanislaus, Conn.

Mar. 10 - 1928,

## 20 UNDERTAKER

M. J. Sadowicki

ADDRESS

705 S. Ann St.

very important. See instructions on back of certificates.

E 31429

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31429

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 Covington St.

2-FULL NAME Ida B. Crawford

(a) RESIDENCE NO. 1739 Covington St

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos.

ST. WARD (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Crawford

6 DATE OF BIRTH (month, day, and year) May 19 1865

7 AGE Years 62 Months 9 Days 18 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa. (State or country)

10 NAME OF FATHER Conrad Shaffer

11 BIRTHPLACE OF FATHER (city or town) Pa. (State or country)

12 MAIDEN NAME OF MOTHER Mary Evans

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)

14 Informant Mrs. Mc Clintock (Address) 1733 Covington

15 AR 9 - 1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7 19 28

17

I HEREBY CERTIFY, That I attended deceased from March 1, 19 28, to Mar 7, 19 28, that I last saw him alive on Mar 7, 19 28.

and that death occurred, on the date stated above, at 9.30 A. M.

The CAUSE OF DEATH\* was as follows:

Cardiac thrombosis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 5 2 1/2

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. F. Hawkins M. D.

3/4, 19 28 (Address) 1 E Randall St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL

Mar 10 19 28

UNDERTAKER

ADDRESS

130 - 84 St

E 31430

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001 E 31430  
REGISTERED NO.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 N. Dallas ST., 8-13 WARD)

## 2. FULL NAME

Willie Branch

## (a) RESIDENCE NO.

1105 N. Dallas

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred 25 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

C

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Lee Branch

## 6 DATE OF BIRTH (month, day, and year)

-- 18 76

## 7 AGE

Years

Months

Days

52

?

?

If LRSS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Domestic

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Crew Va.

## 10 NAME OF FATHER

Joseph Oliver

## 11 BIRTHPLACE OF FATHER (city or town)

Crew Va.

(State or country)

## 12 MAIDEN NAME OF MOTHER

Winters

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Winters

## 14

Informant  
(Address)Lee Branch  
1105 N. Dallas

## 15

Filed

C. HAMMOND JONES, M. Registrar  
MAR 9 - 1928

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) March 8 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar. 1, 1928, to March 8, 1928.

that I last saw him alive on March 8, 1928.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis - Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spec. Exam.

(Signed) W. L. Seely, M. D.

, 19 (Address) 1420 E. Chase

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Crew Va

Mar. 9, 1928

## 20 UNDERTAKER

## ADDRESS

Mrs. R. A. Elliott

1725  
Ashland

E 31431

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *80 Baltimore Ave*CITY OF BALTIMORE: (No. *1213 Light St*ST. *15-68* WARD)2-FULL NAME *Virginia Hamer*(a) RESIDENCE NO. *1807 Poplar St*  
(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred *27* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Charles Hamer*6 DATE OF BIRTH (month, day, and year) *Dec 26 1900*7 AGE Years Months Days / If LESS than 1 day, hrs. or min.  
*27* *2* *11*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md*  
(State or country)10 NAME OF FATHER *John P. Thaw State*11 BIRTHPLACE OF FATHER (city or town) *Md*  
(State or country)12 MAIDEN NAME OF MOTHER *May A. Cobb*13 BIRTHPLACE OF MOTHER (city or town) *Md*  
(State or country)14 Informant *Charles Hamer*  
(Address) *1807 Poplar St*15 *MAR 3 - 1928* *John P. Thaw* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 8 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar 6*, 1928, to *Mar 8*, 1928.that I last saw him alive on *Mar 8*, 1928.and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Acute myocardial Peritonitis*(duration) yrs. mos. ds. *6*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *1807 Poplar St*Did an operation precede death? *No* Date of *Mar 8, 1928*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *D. W. Robertson*, M. D.19 (Address) *827 N Charles St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MONIAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Western Cem*  
*Robert Brooks & Son**3-10-1928*  
*Calhoun*  
*Hollins*

TION is very important. See instructions on back of certificate.



E 31432

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

117 E 31432

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1626 Vincent St. 15-21 Ward)2-FULL NAME Charles R. Edd(a) RESIDENCE NO. 1626 Vincent

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

Signed

9/28/19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificate.

MAR 9 1928

HARVEY JONES, M. D.

Registrar

1400 Mather

E 31433

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31433

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST. *25-72* WARD)2-FULL NAME *Brother Philip Griffith*(a) RESIDENCE NO. *Mt. St. Josephs College* ST. *25-72* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *1900*

7 AGE

*78*

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Massachusetts*

10 NAME OF FATHER

*None*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*None*

12 MAIDEN NAME OF MOTHER

*None*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*None*

14

Informant  
(Address)*Brother Dunston  
Mt. St. Josephs College*

15

Filed

AR 9-1928

*H. H. JONES, R. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-8 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*2-15 1928* to *3-8 1928*that I last saw him alive on *3-8 1928*and that death occurred, on the date stated above, at *2:15 P. M.*

The CAUSE OF DEATH\* was as follows:

*Rheumatic Cardio-vascular-nephritic disease*(duration) yrs. *6* mos. ds.CONTRIBUTORY  
(Secondary)*Broncho-pneumonia*  
(duration) yrs. mos. *5* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*Clinical lab  
Augustine P. Von Schley D.  
St. Agnes 25-72*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*New Cathedral*

20 UNDERTAKER

*A. C. Krause Son*

DATE OF BURIAL

*3/10 1928*

ADDRESS

*703 Hammond St.*

E 31434

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31434

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Playa Apt. Park R. Wilson ST.* *14-20* WARD)

## 2. FULL NAME

*Maria Winchester*

## (a) RESIDENCE NO.

*Playa Apt's Park R. Wilson ST.*

(Usual place of abode)

Length of residence in city or town where death occurred

*70* yrs. *3* mos. *25* ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female White*

## 4 COLOR OR RACE

*American*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Nov. 11, 1857*

## 7 AGE

*70*

Years

*3*

Months

*28*

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

## 10 NAME OF FATHER

*John Marshall Winchester*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*unknown*

## 12 MAIDEN NAME OF MOTHER

*Anna Gordon Price*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Wilmington Delaware*

## 14

Informant (Address)

*Maude S. Paulding 1269 Madison Ave NYC*

9-1928

19

STAMPSON JONES, M. L.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 8, 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*March 5, 1928, to March 8, 1928,*that I last saw her alive on *March 8, 1928,*and that death occurred, on the date stated above, at *11<sup>00</sup> a.m.,*

The CAUSE OF DEATH\* was as follows:

*Acute Pulmonary Oedema with Hemoptysis (Lat Rec.)*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Acute Bronchitis, Hypertension*

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *X-ray & Autopsy*(Signed) *J. A. Chas. and* M. D.Address *300 W. Calvert St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

*St. Johns Naverly*

## 20 UNDERTAKER

*Ceney & Jenkins Sons Co*

## DATE OF BURIAL

*Mar 10, 1928*

## ADDRESS

*McClure Orchard St*

TION is very important. See instructions on back of certificates.

E 31435

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31435

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1830 Mc Henry* St. *14-28* Ward)2-FULL NAME *Baby Boy Albin*

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *1830 Mc Henry* St. .... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Male*

4-COLOR OR RACE,

*White*

5-Single

*Single*  
Married,  
Widowed,  
or Divorced.  
(Write the word.)5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of6-DATE OF BIRTH (month, day and year) *Mar 8 1928**Premature*

If LESS than 1 day,

... hrs. or *46* min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work*None*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town),  
(State or Country),*Maryland*10-NAME OF  
FATHER,*Charles Albin*

11-BIRTHPLACE

OF FATHER (city or town),  
(State or Country),*Maryland*12-MAIDEN NAME  
OF MOTHER,*Agnes Grafton*13-BIRTHPLACE  
OF MOTHER (city or town),  
(State or Country),*Maryland*

14-

(Informant) .....

(Address) .....

15-

Filed *9-1928*

C. HAMPTON JONES, JR.

Registrar

0241

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *Mar 8 1928*17- I HEREBY CERTIFY, That I attended deceased from  
*Mar 8* 1928 to *Mar 8* 1928that I last saw him alive on *Mar 8* 1928and that death occurred, on the date stated above, at *2:15* p.m.

The CAUSE OF DEATH\* was as follows:

*Prematurity*CONTRIBUTORY  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted  
If not at place of death?Did an operation precede death? *No* Date of .....Was there an autopsy? *No*What test confirmed diagnosis? *Phys exam*(Signed) *Hugh H. Reynolds*, M. D.19 (Address) *University Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL,

DATE OF BURIAL,

*JOPKINS HOSPITAL**MAR 9 - 1928*

20-UNDERTAKER,

ADDRESS

*General Hospital*



E 31436

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31436

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital*)

WARD)

2-FULL NAME *Patricia Gorman*(a) RESIDENCE NO. *1415 Eastern Ave*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male white*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*39?*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Labors - 040*

9 BIRTHPLACE (city or town) (State or country)

*me.*

10 NAME OF FATHER

*E*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*?*

12 MAIDEN NAME OF MOTHER

*?*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*?*

14

Informant (Address)

15 *1928 C. HAMPTON JONES, M. D.*

Filed

19

Registrar

0244

THE MORGUE

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-1-1928*

17

I HEREBY CERTIFY, That I attended deceased from *12-23*, 19 *27*, to *3-1*, 19 *28*that I last saw him alive on *3-1-*, 19 *28*and that death occurred, on the date stated above, at *3:45* p.m.

The CAUSE OF DEATH\* was as follows:

*Consumption of pancreas with metastasis*(duration) *unknown*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *12-28-27*Was there an autopsy? *no*What test confirmed diagnosis? *Operation*

(Signed)

, 19 (Address)

*Blueswee, M. D.*  
*Balti City Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner of Health.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31437

E 31437

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3-4 ST. WARD)2-FULL NAME Charles Young(a) RESIDENCE No. 23 S. D'Almeida ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

7

6 DATE OF BIRTH (month, day, and year)

7

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Severer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

John Young

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Residence

15

1028

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/1928

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 14, 1927, to Nov. 1, 1928that I last saw him live on Nov. 1, 1928and that death occurred, on the date stated above, at 5:00 A. M.

The CAUSE OF DEATH\* was as follows:

Diabetes mellitus(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sugar(Signed) C. Hampton Jones M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

JOHN HOPKINS HOSPITALCommissioner of Health.

MAR 9 - 1928

Wm. E. WOODALL

E 31438

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31438

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST. 16-27 WARD)2-FULL NAME Richard G. Gill(a) RESIDENCE NO. 516 W. Gilman ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred P. yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Caucasian ?5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salvage 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina10 NAME OF FATHER James Gill11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina12 MAIDEN NAME OF MOTHER Julia ?13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14

Informant (Address) Records

15

- 1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27/1928

17

I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1928, to Feb. 27, 1928, that I last saw him alive on Feb. 27, 1928

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH\* was as follows:

Acute myocardial infarction  
myocarditis, chronic  
suppurative(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? General & Sub.(Signed) C. Hampton Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health

MAR 9 - 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31439

## CERTIFICATE OF DEATH.

90 E 31439

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 307 N. Exeter St. 5-8 Ward)

2-FULL NAME James Barnes.

(a) RESIDENCE NO. 307 N. Exeter St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

St. Ward

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)

Male.

White.

Do not know.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Do not know.

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

55

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Do not know.

10 NAME OF FATHER

Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Do not know.

12 MAIDEN NAME OF MOTHER

Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Do not know.

14

Informant Police Report, C.D.

(Address)

G. HANCOCK JONES, M. D.

15

Fwd

1928

19

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26, 1928 1928

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.) and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency.  
Acute dilatation of the heart.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

M. D.

E/6 . 1928 (Address)

1017 S. Charles St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

19

ADDRESS

MAR 9 - 1928

2248.

THE MORGUE

OF DEATH in plain terms, so that it may be properly understood.  
very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31440

## CERTIFICATE OF DEATH.

E 31440

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 12-70 Ward)2-FULL NAME Henrietta Dickson(a) RESIDENCE NO. Walbert Apts.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

Female

White

Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Abt. ---1845

7 AGE

23 Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

Abt. 82

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer-

9 BIRTHPLACE (city or town) Charleston(State or country) South Carolina10 NAME OF FATHER Dr. Samuel Henry Dickson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

South Carolina12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant Mrs. J. J. Brunt(Address) 1522 Bolton Street

15

1928 C. HAMMOND JONES, M.D.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 8, 1928

192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an  
(Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said  
(Inquest, autopsy or inquiry.)I find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Burns of body, S. leg  
injury of canal, accident  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

(Address) 1639 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Loudon Park CemeteryMar. 10 1928

20 UNDERTAKER

ADDRESS 1003W. Baltimore  
St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31441

E 31441

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1709 E Madison* ST. *7-13* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *1709 E Madison* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 2, 1895*

7 AGE

32

Years

Months 3

Days 4

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Construction work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Samuel Yorkman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Oscar Askins (Brother in law) 1709 Madison St. Bk. 11

15

Filed 1928, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 6* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *Dec 27* to *March 6*, 19 *28*, that I last saw him alive on *March 5*, 19 *28*, and that death occurred, on the date stated above, at *120 P. m.*

The CAUSE OF DEATH\* was as follows:

Pulm. Tuberculosis

(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

Physical

(Signed)

3/7, 1928

(Address)

R. J. Yorkman, M. D. 1424 E. Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Zion Cem.

DATE OF BURIAL

Mar 10 1928

20 UNDERTAKER

Wm. G. Locks

ADDRESS

1302 Jefferson



E 31442

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1614 Milliman St. 7-13 Ward)2-FULL NAME Alyandria Redwine(a) RESIDENCE NO. 1614 Milliman St. N. Carolina Ward(Usual place of abode)  
Length of residence in city or town where death occurred 0 yrs. 3 weeks mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race colored 5 Single, Married, Widowed, or Divorced. (write the word) married5a If married, widowed, or divorced  
HUSBAND of Burnetta Redwine  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18817 AGE Years 47 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator operator  
(b) General nature of industry, business, or establishment in which employed (or employer) do  
(c) Name of employer9 BIRTHPLACE (city or town) North Carolina  
(State or country)10 NAME OF FATHER (unknown) Redwine11 BIRTHPLACE OF FATHER (city or town) North Carolina  
(State or country)12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) North Carolina  
(State or country)14 Informant Burnetta Lams Redwine  
(Address) 1614 Milliman St.15 Filed 1928 FRANKLIN JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7-28 192817 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1928, to Mar 7, 1928, that I last saw him alive on Mar 6, 1928, and that death occurred, on the date stated above, at 9<sup>15</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Phthisis  
May 1927 (duration) 7 yrs. 0 mos. 0 ds.  
CONTRIBUTORY Pulmonary Hemorrhage  
(Secondary)  
(duration) 8 yrs. 0 mos. 4 ds.18 Where was disease contracted?  
If not at place of death? At Ham Sp. city, N.Y.Did an operation precede death? no Date of.....Was there an autopsy? noWhat test confirmed diagnosis? ✓(Signed) Edward Fisher, M. D.3.7.1928 (Address) 1612 E Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Astbury Cmn. Date of Burial Mar 11 192820 UNDERTAKER Mrs J. J. Locks ADDRESS 1302 Jefferson St.OF DEATH IN PAID FORMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.  
very important. See instructions on back of certificates.

E 31443

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31443

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home St.* ST. *11-15* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Baldwin Mrs. Jennie*(a) RESIDENCE NO. *1203 St Paul* ST., *Baltimore* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Robt Baldwin*6 DATE OF BIRTH (month, day, and year) *Mar 3 1853*7 AGE *75* Years Months Days If LESS than 1 day, hrs. or min. *0 6*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *N.Y.*10 NAME OF FATHER *Ansel Bascom*11 BIRTHPLACE OF FATHER (city or town) (State or country) *N.Y.*12 MAIDEN NAME OF MOTHER *Jane A. Nichols*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *N.Y.*14 Informant *Nora W. B. Campbell* (Address) *201 W. 81st ST New York City*15 Filed *1928* *C. HAMPTON JONES, Jr.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 9 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 28*, 19*28*, to *March 4*, 19*28*, that I last saw her alive on *Mar 4*, 19*28*, and that death occurred, on the date stated above, at *12 noon* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*(duration) yrs. mos. *9* ds.CONTRIBUTORY *Arterial Sclerosis* (Secondary)(duration) *14* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *Feb 28, 1928*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *George B. Buel* M. D.*Mar 9 1928* (Address) *Church Home St. Baltimore*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Green Mount Cem* *Mar 10 1928*

20 UNDERTAKER

ADDRESS

*Henry J. Jenkins & Son* *McClure & Dickson*

TION is very important. See instructions on back of certificates.

E 31444

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31444

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. WARD)

2-FULL NAME *Richard D. Smith*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *1101 N. Broadway* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *34* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of or WIFE of *Annie D. Smith*6 DATE OF BIRTH (month, day, and year) *May 5 - 1854*7 AGE Years *73* Months *10* Days *3* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *James D. Smith*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Eliza Bullard*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*14 Informant (Address) *Records*15 File *1928* *HAMPSON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/8/1928*17 I HEREBY CERTIFY, That I attended deceased from *Dec. 3, 1928* to *Mar. 8, 1928* that I last saw him live on *Mar. 8, 1928*, and that death occurred, on the date stated above, at *6:00 p. m.*

The CAUSE OF DEATH\* was as follows:

*Solar pneumonia*  
*Pyrexia*(duration) yrs. *2* mos. *10* ds.CONTRIBUTORY *Myocarditis* *causis*

(Secondary) (duration) ? yrs. mos. ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *General & Sub*(Signed) *C. D. Jones* M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Calvary*

DATE OF BURIAL

UNDERTAKER *Reston*ADDRESS *1723 N. ...*

E 31445

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31445

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4808 Frederick Ave. ST. 28-71 WARD)2. FULL NAME John M. Hale(a) RESIDENCE NO. 4808 Frederick Ave. ST. 28-71 WARD(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)malewhiteSingle5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Aug 13 1891

7 AGE

Years

Months 6Days 26If LESS than  
1 day, hrs.  
or min.68

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workRetired(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

B & O R.R.9 BIRTHPLACE (city or town)  
(State or country)Baltimore Md.

10 NAME OF FATHER

John M. Hale11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Ireland

12 MAIDEN NAME OF MOTHER

Ellen Gordon13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Ireland

14

Informant  
(Address)Miss Helen Gordon  
4808 Frederick Ave.

15

File

1028C. HAMPTON JONES, R. D.

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH, (month, day, and year) Mar 9 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1923, to Mar 9, 1928,that I last saw him alive on March 9, 1928,and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis(duration) 5 yrs. mos. ds.CONTRIBUTORY (Secondary) Cerebral Sclerosis(duration) 7 yrs. mos. ds.18 Where was disease contracted  
if not at place of death? ☒Did an operation precede death? ☒ Date ofWas there an autopsy? noWhat test confirmed diagnosis? no(Signed) Robert H. Hilditch, M. D.3/9/28 (Address) 2112 Myrtle Ave.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

London Court CareMar 12 1928

20 UNDERTAKER

ADDRESS

John J. Cowan & Son901 Baltimore



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31446

## CERTIFICATE OF DEATH.

E 31446

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin Sq. 1444*)St. *21* Ward

## 2-FULL NAME

*Henry J. Schlott hober*

## (a) RESIDENCE NO.

*1212 Carroll*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Catherine M. Schlott hober*

6 DATE OF BIRTH (month, day, and year)

*March 1<sup>st</sup> 1867*

7 AGE

Years

Months

Days

If LESS than  
1 day.....hrs.  
or.....min.*61**—**6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....*Retired*(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town)

(State or country)

*Balto,*

10 NAME OF FATHER

*Henry J. Schlott hober*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Christian Zimmerman*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant  
(Address)*Catherine M. Schlott hober  
1212 Carroll St*

15

*C. HAMPTON JONES, M. D.  
1928*

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 7<sup>th</sup> 1928*

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry*

(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said *Inquest*And that said deceased came to this death  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Fractured Skull  
Quicker jumped out  
3<sup>rd</sup> story Franklin Sq. Hop  
being treated for  
Bleeding, poisoning  
died 8<sup>th</sup> March 1928  
Mch 8<sup>th</sup> 1928 (Address) *Curtis Bay,**\*State the Disease Causing Death, or if death from Violent  
causes, State the Cause and Nature of Injury and (if known) Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR

REMOVAL

Date of Burial

*Western**Mar 10, 28*

20 UNDERTAKER

ADDRESS

*Mrs. John W. Tufel & Son 801 W. Fayette*

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.



E 31447

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31447

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Bradford

ST. 1-3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME GEORGE F. BEHRNS(a) RESIDENCE NO. 607 S. Bradford

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Margaret Behrns6 DATE OF BIRTH (month, day, and year) July 2, 1876

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.5185

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crane Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co.9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER Frederick Behrns

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) Not Known  
(State or country)

14

Informant Margaret Behrns (Wife)(Address) 607 S. Bradford St.

15

1928 C. HAMILTON JONES, U. S.  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1928 to March 7, 1928.that I last saw alive on March 7, 1928.and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH\* was as follows:

Lobar PneumoniaCONTRIBUTORY Cardiac Failure  
(Secondary) (duration) yrs. mos. 4 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted At Home  
if not at place of death?Did an operation precede death? Yes Date of —Was there an autopsy? YesWhat test confirmed diagnosis? Physical signs

(Signed)

3/8/28 Chas. J. Neer M. D.  
(Address) 408 2nd Park Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park CemeteryMar. 10 1928

20 UNDERTAKER

ADDRESS

Henry Sander & Sons Inc.1710 Fleet S

TION is very important See instructions on back of certificates.

E 31448

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

99-2 E 31448

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 S. Highland Ave.

ST. 76-2 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME KATHERINE LANG

(a) RESIDENCE No. 12 S. Highland Ave.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

80

yrs. mos.

How long in U. S., if of foreign birth? 80 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Jacob Lang

6 DATE OF BIRTH (month, day, and year) January 15, 1846

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

82

1

24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

Germany

10 NAME OF FATHER John Fritz

11 BIRTHPLACE OF FATHER (city or town; State or country)

Germany

12 MAIDEN NAME OF MOTHER Anna K. Behr

13 BIRTHPLACE OF MOTHER (city or town; State or country)

Germany

14

Informant Mrs. Frederick P. Gerecht (Daughter)  
(Address) 12 S. Highland Ave.

15

Filed

1928

G. HAMMOND JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1928

17

I HEREBY CERTIFY, That I attended deceased from Oct 1 - 1927 to Mar. 9 - 1928, that I last saw her alive on Mar. 9 - 1928,

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis  
Bronchial Asthma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Dilatation Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? none

What test confirmed diagnosis?

(Signed)

Gustav C. Shieff M. D.

, 19 (Address) 16 h. Kenwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

First Evangelical Cemetery

Mar. 11 1928

20 UNDERTAKER

Henry Sander &amp; Sons Inc

ADDRESS

1710 Fleet St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31449

31449

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *534 N. Fulton St.*) WARD *7-001*

## 2-FULL NAME

*Edward Wimmer*

## (a) RESIDENCE NO.

*534 N. Fulton St.* WARD *7-001*

(Usual place of abode)

Length of residence in city or town where death occurred *71* yrs. *11* mos. *11* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of *Elizabeth M. Wimmer* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *March 25, 1859*7 AGE Years *77* Months *11* Days *11* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Piano Maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Retired*9 BIRTHPLACE (city or town) (State or country) *Gowa*10 NAME OF FATHER *John G. Wimmer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Wimmer*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Miss Emma E. Wimmer* (Address) *534 N. Fulton St.*15 *C. HAMMOND JONES, JR.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 7, 1928*17 I HEREBY CERTIFY, That I attended deceased from *Aug. 1926* to *March 7, 1928*, that I last saw him alive on *March 7, 1928*and that death occurred, on the date stated above, at *4:50 P. M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Apoplexy*(duration) *1* yrs. *6* mos. — ds.CONTRIBUTORY *Myocardial insufficiency* (Secondary) (duration) *2* yrs. *2* mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of —Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *M. B. Bowman and Good*, M. D.*3/8, 1928* (Address) *626 N. Gilman St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Cemetery* *Mar 10 1928*

20 UNDERTAKER

ADDRESS

*For gardeners. Son* *217 S. Bon*

TION is very important. See instructions on back of certificate.

9 1928

E 31450

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

46 E 31450

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5300 St. Charles Ave.* *27-55* WARD)2-FULL NAME *Ida E. Shaw*(a) RESIDENCE No. *5300 St. Charles Ave.* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *widow*

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of *Howard E. Shaw*6 DATE OF BIRTH (month, day, and year) *Aug 29-1862*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*63**6**18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto Co*  
(State or country)10 NAME OF FATHER *Wm Shaffer*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *MD*12 MAIDEN NAME OF MOTHER *Anna Mahan*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Germany*

## PARENTS

14 Informant *Clara J. McDonnell*  
(Address) *5253 St. Charles Ave.*

## 15

File *1928*

19

HAMPSON JONES, II. C.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 9 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr. 1927* to *Mar 9 1928*.that I last saw him alive on *Mar 8 1928* and that death occurred, on the date stated above, at *12:45 pm*

The CAUSE OF DEATH\* was as follows:

*Uterine Carcinoma*(duration) *2 yrs.*

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death? *Unknown*Did an operation precede death? *yes*Date of *Nov. 1927*Was there an autopsy? *no*What test confirmed diagnosis? *symptomatic*(Signed) *Henry Russell*

M. D.

13/9, 1928 (Address) *3902 Broadway Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Lorraine Cemetery*

DATE OF BURIAL

*Mar 10 1928*

20 UNDERTAKER

*Harry W. Ehler*

ADDRESS

*1944 W. North Ave*

TION is very important See instructions on back of certificates.

E 31451

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 31451

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Wilmslow Ave

2-FULL NAME Mr. Charles De Witt Sr.

(a) RESIDENCE No. 510 Wilmslow Ave - Roland Park ST.,

(Usual place of abode)  
Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)  
yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Ruth DeWitt

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

68

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Glass Ware Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Columbus Georgia

10 NAME OF FATHER

Abraham DeWitt

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

unknown

12 MAIDEN NAME OF MOTHER

Sarah Phelps

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Georgia

14 Informant

(Address)

Charles DeWitt Jr.

15

1928

19 JANUARY 12, 1928

Registrar

27-53

ST.

WARD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 6<sup>th</sup> 1927 to March 8<sup>th</sup> 1928  
that I last saw him alive on March 8<sup>th</sup> 1928  
and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic myo & endo Carditis  
arterio Sclerosis Nephritis

many years

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary) 2 mo

General Anasarca (duration) many yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Just plain physical Diag.

(Signed)

W. L. R. Clarke

M. D.

19

(Address)

1 St. Johns Rd - Roland Park Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

Chas. G. Black 742 W North Ave

ADDRESS

March 10 1928

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31452

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31452

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2627 Maryland Ave. Ward 12-50)

## 2-FULL NAME

Alice Key Lay

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2627 Maryland Ave. Ward 12-50

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Harry B. Lay

6 DATE OF BIRTH (month, day, and year)

Dec 8 1874

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

5330

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Thurmont

(State or country)

Md

10 NAME OF FATHER

John A. Renner

11 BIRTHPLACE OF FATHER (city or town)

Lewistown Md

(State or country)

12 MAIDEN NAME OF MOTHER

Sophie Gilbert

13 BIRTHPLACE OF MOTHER (city or town)

Thurmont Md.

(State or country)

14

Informant

(Address)

Kathryn M. Dowell2627 Maryland Ave

15

1928C. HAMMOND JONES, M.D.

PR

RECEIVED

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 - 2817 I HEREBY CERTIFY, That I attended deceased from Feb 14 1928 to March 8 1928that I last saw her alive on March 8 1928and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) La. Richardson (Address) 1126 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Thurmont Md.

Date of Burial

March 11 1928

20 UNDERTAKER

Chas. S. Black 742 W. North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31453

## CERTIFICATE OF DEATH

E 31453

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1530 Pennington*)2-FULL NAME *Ottelger Lidts*(a) RESIDENCE NO. *1530 Pennington* St.

(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO. *25-77*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

2 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day...hrs. or...min..

*77**2**6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*none*

9 BIRTHPLACE (city or town)

(State or country)

*Europe*

10 NAME OF FATHER

*Don't Know*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Europe*

12 MAIDEN NAME OF MOTHER

*Don't Know*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Europe*

14

Informant

(Address)

*Mrs. Hattie Meyers**1530 Pennington ave*

15

1928

*C. HAMPTON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 8, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 7, 1928, to Mar. 7, 1928*that I last saw *him* alive on *March 7, 1928*and that death occurred, on the date stated above, at *3 P. M.*

The CAUSE OF DEATH\* was as follows:

*Bunches Pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*Wm. S. J. J.*

M. D.

Date of *Mar. 8, 1928* (Address) *1530 Pennington Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Cedar Hill Cem*

Date of Burial

*Mar. 10 1928*

20 UNDERTAKER

*Margaret A. Flynn*

ADDRESS

*422 Light*

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31454

E 31454

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. \_\_\_\_\_ St., \_\_\_\_\_ Ward)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year)

Aug 31<sup>st</sup>

1854

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

73

6

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto

10 NAME OF FATHER

Saml T. Taylor

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

C. Reed

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant  
(Address)C. Fricke  
3756 Culver St.

15 Filed

C. HAMPTON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 7<sup>th</sup> 1928

17

I HEREBY CERTIFY that I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(duration)

at once

CONTRIBUTORY  
(Secondary)

(Signed)

Thos. B. Norton

M. D.

(Address)

Curtis Bay

\*State the Disease Causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds.

In the

State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Travis Christman May 10 28

20 UNDERTAKER

ADDRESS

George R. Schwalb 2101 Buck Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31455

## CERTIFICATE OF DEATH.

90 E 31455

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Bolton St. 14-70 WARD)

2-FULL NAME Mary Alice Davis

(a) RESIDENCE NO. 2004 Bolton St  
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of John F. Davis

6 DATE OF BIRTH (month, day, and year) April 18, 1897

7 AGE 81 Years 10 Months 9 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria, La

10 NAME OF FATHER Andrew Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss.

12 MAIDEN NAME OF MOTHER Elizabeth Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Miss.

14 Informant Alice D. Hardner.  
(Address) 2004 Bolton St

15 File 10 1928 C. HAMPSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1926, to March 9, 1928, that I last saw her alive on March 9, 1928, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH\* was as follows:

cardio-vascular

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) coma

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. S. Love, M. D.

3/9, 1928 (Address) 836 W. North a

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cem

DATE OF BURIAL

3-10-1928

20 UNDERTAKER

Henry W. Jenkins Sons Co

ADDRESS

Richard McCulloch



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31456

## CERTIFICATE OF DEATH.

E 31456

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2574 Frederick St., 69 Ward)

## 2-FULL NAME

Edward M. Komoser

## (a) RESIDENCE NO.

2574 Frederick St., 69 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct 9<sup>th</sup> 1847

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.804529

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workRetired(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Balto

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant  
(Address)Louis M. Komoser  
2574 Frederick Ave

## 15 Filed

C. HAMPSON JONES, M. D.

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 8<sup>th</sup> 1928

## 17

I HEREBY CERTIFY that I took charge of the

remains described above, held an

(Inquest, autopsy, or inquiry)

thereon and from the evidence obtained by said

find that said deceased came to

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Guicide by Inhaling  
illuminating Gas  
Dead when found.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(Signature) Thos. B. Norton M. D.

(Coroner)

May 8<sup>th</sup> 1928 (Address) Curtis Bay\*State the Disease Causing Death, or in deaths from violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See rate schedule for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park Cemetery May 10-1928

## 20 UNDERTAKER

ADDRESS

Charles J. Schwalb 5057 Monroe St.tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is  
OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

10 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31457

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31457

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 2129 Ward)2-FULL NAME Eugene J. Winkler(a) RESIDENCE NO. 929 S. Paca St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Clara Winkler6 DATE OF BIRTH (month, day, and year) Aug 12 - 18747 AGE Years 53 Months 6 Days 25 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Harness Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Balto. Md10 NAME OF FATHER Joseph Winkler11 BIRTHPLACE OF FATHER (city or town) Balto Md  
(State or country)12 MAIDEN NAME OF MOTHER Mary Walz13 BIRTHPLACE OF MOTHER (city or town) Balto Md  
(State or country)14 Informant Leona Bell  
(Address) 929 S. Paca St15 C. HAMPTON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said autopsy  
(Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

struck by automobile truck.  
accident.  
Fracture of skullCONTRIBUTORY Internal Hemorrhage  
(Secondary)(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Eugene Bell M. D.  
(Coroner)3/8, 1928 (Address) 2739 Eastern Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Fondren Park 3-12 1928

20 UNDERTAKER ADDRESS

Bernard C. Hark, 1000 S. Paca St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E. 31458

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31458

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4301 Walnut Ave*ST. *28-66* WARD)

## 2-FULL NAME

*Charles Bender*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*4301 Walnut Ave.*

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *10* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*May 9, 1890*

## 7 AGE

*37* YearsMonths *10*

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Eupt*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

*N.J. Louis Bender*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Hammerville N.J.*

## 12 MAIDEN NAME OF MOTHER

*Erline Chesman*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*New York*

## 14

Informant (Address)

*Mrs. James D. Masterson Atlantic Highlands N.J.*

## 15

Date

*10 1928**C. HAMMON JONES, M.D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*3/9 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*3/4/28*, 19*28*, to *3/9*, 19*28*.that I last saw him alive on *3/1*and that death occurred, on the date stated above, at *11 55 p.m.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(duration) yrs. mos. *7* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*Clinical Augustus P. von Schuf M.D.**1928 (Address) Riggs Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*Frederick N.J.**3/12 1928*

## 20 UNDERTAKER

*Robert Brookerson**Baltimore Hollins*

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31459

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1528 Ashland Ave St. 7-13 Ward)

2-FULL NAME John Williams

(a) RESIDENCE NO. 1528 Ashland Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1895

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 33

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

N.C.

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) N.C.  
(State or country)

12 MAIDEN NAME OF MOTHER Bettie Franklin

13 BIRTHPLACE OF MOTHER (city or town) N.C.  
(State or country)

14 Informant Bettie Williams  
(Address) 1528 Ashland Ave

15 Filed 1928 19 HAMPSON JONES, Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Probably Lobar)

(duration) .....yrs. ....mos. 10 ds.

## CONTRIBUTORY (Secondary)

(Signed) J. H. Potter M. D.  
(Coroner)

3/10/28 (Address) 305 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death:

Former or usual residence:

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Ashbury Cemetery Mar. 11, 1928

20 UNDERTAKER ADDRESS

Mrs. R. A. Elliot 725 Ashland

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31460

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 6-9 Ward)2-FULL NAME Frank A. Burnham, Jr.(a) RESIDENCE NO. 601 N. Castle St St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

white

5 Single, Married, Widowed,  
or Divorced, (write the word)  
single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 1/27

7 AGE

Years

Months

Days

If LESS than

1 day.....hrs.

or.....min.

4

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

none

(b) General nature of industry,  
business, or establishment in  
which employed, (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER Frank Burnham, Sr

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Mo.

12 MAIDEN NAME OF MOTHER Marie Emery

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto., Md.

14

Informant Father

(Address)

10 1928

19

C. HAMPTON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 8/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry and that said deceased came to his death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia (Primary)

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY

(Secondary)

(Signed)

(Coroner)

3/9/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Oak Lawn

Mar 10 1928

20 UNDERTAKER

ADDRESS

Geo M. Smith &amp; Son

811 N. W. 4th

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



E 31461

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

66 E 31461

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 N. Mount St.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Nelson

(a) RESIDENCE NO. 300 N. Mount St.

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

20 yrs. / ? mos. ?

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Isaac Nelson (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2, 1893

7 AGE 34 35 8 5 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

(c) Name of employer

Unemployed

9 BIRTHPLACE (city or town) Howard Co. Md. (State or country)

10 NAME OF FATHER John Howard

11 BIRTHPLACE OF FATHER (city or town) Ga. (State or country)

12 MAIDEN NAME OF MOTHER Jimima Williams

13 BIRTHPLACE OF MOTHER (city or town) Howard Co. Md. (State or country)

14 Informant Vic. Howard (Address) 1624 W. Saratoga St.

15 10 1928 19 HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7-1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20th. 1928 March 8th. 1928

that I last saw her alive on March 6th. 1928

and that death occurred, on the date stated above, at 6:30p.m.

The CAUSE OF DEATH\* was as follows:

Acct Parenchamatiuous nephritis

(duration) yrs. mos. 18 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? NO. Date of

Was there an autopsy? NO.

What test confirmed diagnosis? Urinaylasis

(Signed) Walter J. Jackson, M. D.

1634 W. Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

MOUNT AUBURN

3-10-28

20 UNDERTAKER

Joseph A Lively 409 N Mount Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



E 31462

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 31462

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2717 W. Balt. St. ST. 70-69 WARD)

2. FULL NAME John T. E. Westphal

(a) RESIDENCE NO. 2717 W. Baltimore St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Son

6 DATE OF BIRTH (month, day, and year) March 15, 1879

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

28

11

22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

Insurance

(c) Name of employer

Mutual Ins. Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George Westphal

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Anne Wickes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Mrs George Westphal 2717 W. Baltimore St.

MAR 10 1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1928

17

I HEREBY CERTIFY That I attended deceased from Feb 28, 1927 to March 7, 1928, that I last saw him live on March 6, 1928, and that death occurred, on the date stated above, at 1 1/2 m.

The CAUSE OF DEATH\* was as follows:

Apoplexy  
Chronic Interstitial Nephritis (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 7 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Positive

(Signed) Dr. W. H. Jones, M. D.

3-7-1928 (Address) 708 Enoch St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cem.

20 UNDERTAKER

Chas. L. Stearns

DATE OF BURIAL

March 10, 1928

ADDRESS

1501 E. Fort Ave.

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31463

E 31463

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *111 N Monroe* ST. *14-27* WARD) *90*

## 2-FULL NAME

*Martha Jane Rea*(a) RESIDENCE NO. *111 N Monroe* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *84* yrs. *10* mos. *6* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widow*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Joseph B. Rea*

6 DATE OF BIRTH (month, day, and year)

*May 2 - 1843*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*84**10**6*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*city*

10 NAME OF FATHER

*Wm Arnold*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*city*

12 MAIDEN NAME OF MOTHER

*Ellen Turner*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*city*

14

Informant (Address)

*Eren Rea 111 N Monroe*

15

U 1928

*C. HAMPSON JONES, M. D. Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar. 8 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 15, 1928 to Mar. 8, 1928*that I last saw her alive on *Mar. 7, 1928*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*old age*

(duration)

*2* yrs. *2* mos. *2* ds.

CONTRIBUTORY (Secondary)

*Cardiac Dilatation*

(duration)

*1* yrs. *1* mos. *1* ds.

18 Where was disease contracted if not at place of death?

*Unknown*

Did an operation precede death?

*no*

Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Physical*

(Signed)

*Robert S. Blake*

M. D.

, 19

(Address)

*719 Med Arts Bldg*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Greenmount*

DATE OF BURIAL

*Mar 10 1928*

20 UNDERTAKER

*W. J. Tucker & Son*

ADDRESS

*Nat'l Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31464

## CERTIFICATE OF DEATH.

E 31464

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1720 Brunt 14-20 Ward)2-FULL NAME Peter Hopkins(a) RESIDENCE NO. 1720 Brunt St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race C 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Hopkins6 DATE OF BIRTH (month, day, and year) 3 7 18767 AGE Years 52 Months 7 Days 7 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler(b) General nature of industry, business, or establishment in which employed (or employer) OP

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Annapolis Co Md10 NAME OF FATHER Peter Hopkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md12 MAIDEN NAME OF MOTHER Antoinette

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md14 Informant Jennie Hopkins  
(Address) 1720 Brunt15 Filed C. HAMPTON JONES, M. D.  
RKH Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1928 1917 I HEREBY CERTIFY, That I attended deceased from March 6, 1928, to March 8, 1928, that I last saw him alive on March 8, 1928, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH\* was as follows:

Bilateral Lobar Pneumonia  
(duration) ..... yrs. .... mos. 15 ds.

## CONTRIBUTORY

(Secondary)

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? 70 Date of.....Was there an autopsy? 70

What test confirmed diagnosis?

(Signed) J. McRae, M. D.3/9, 1928 (Address) 1126 Grand Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Anthony's

Date of Burial

3/10/28

20 UNDERTAKER

ADDRESS 578Samuel H. Hensley Middle

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10 1928

E 31465

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31465

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital 4-25* ST. *4-25* WARD)2. FULL NAME *John Wilson*(a) RESIDENCE No. *201 Arch*

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.ST. *4-25* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *Negro*5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Widow*6 DATE OF BIRTH (month, day, and year) *1877*

7 AGE

Years *51*

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Labourer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Headley Co Virginia*10 NAME OF FATHER *James Wilson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14

Informant (Address) *Robert Wilson 817 W Lee St*

15

Filing

G. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/8/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *3/4/28*, 19, to *3/8/28*, 19, that I last saw him alive on *3/8/28*, 19, and that death occurred, on the date stated above, at *2 P.* m. The CAUSE OF DEATH\* was as follows:*Lobar pneumonia*(duration) yrs. mos. *4* ds.CONTRIBUTORY (Secondary) *uremia*(duration) yrs. mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *H. Lawrence Fabinger, M. D.*, 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS *578*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of cause of death on back of certificate.

R 10 1928



31466

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31466

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 664 W Franklin ST. 17-25 WARD)

3/10/28  
K.W. Jones  
J. W. Jones  
FULL NAME Mary Sikelto

(a) RESIDENCE NO. 664 W Franklin ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Sikelto

6 DATE OF BIRTH (month, day, and year) Dec. 18- 1860

7 AGE Years 67 Months 2 Days 20 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) State (State or country)

10 NAME OF FATHER Vincent Sikelto

11 BIRTHPLACE OF FATHER (city or town) State (State or country)

12 MAIDEN NAME OF MOTHER Mary Giorgio

13 BIRTHPLACE OF MOTHER (city or town) State (State or country)

14 Informant Cemetery Sikelto (Address) 664 W Franklin

15 1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 8- 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1928, to Mar. 8- 1928.

that I last saw her alive on March 7, 1928.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Primary) (duration) yrs. mos. 21 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys. examination

(Signed) H. W. Phils M. D.

3-8, 1928 (Address) 1301 Paul

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery 2/13 1928

20 UNDERTAKER

George J. Ruth 1735 Harford Ave

tion should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 10



E 31468

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31468

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 649 First St. Westport St. Ward)

2-FULL NAME Naomi DeFontes

(a) RESIDENCE NO. 649 First St. Westport St. Ward

Length of residence in city or town where death occurred 1 yrs. 6 mos. 22 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 16 1926

7 AGE Years Months Days 1 6 22 IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Joseph DeFontes

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Maida Ellison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis, Md.

14 Informant Joseph DeFontes (Father) (Address) 649 First St.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1928, to Mar 9, 1928,

that I last saw her alive on Mar 5, 1928,

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia

CONTRIBUTORY (duration) yrs. mos. 12 ds. (Secondary) Measles about two weeks ago

18 Where was disease contracted (duration) yrs. mos. ds.

if not at place of death? 506 Montgomery St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm. E. Dwyer M. D.

3/10, 1928 (Address) 1319 Light St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cemetery

## 20 UNDERTAKER

John H. Denny

Date of Burial

Mar. 12 1928

ADDRESS

715 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state NAME OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 10 1928

G. HAMMOND JONES, M.D.

## HEALTH DEPARTMENT-CITY OF BALTIMORE

E 31469

## CERTIFICATE OF DEATH

REGISTERED NO.

E 31469

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2528 E 16th Ave. 8-16 St. Ward)

2-FULL NAME *Amie S Bohanan*

(a) RESIDENCE No. 2528 E 16th Ave. Ward

Length of residence in city or town where death occurred: yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth: yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*John Bohanan*

6 DATE OF BIRTH (month, day and year)

*March 27/76*

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or min..

*51**11**12**18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*at home*

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore Md*

10 NAME OF FATHER

*Patrick Williams*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Amie C. Keffe*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ireland*

PARENTS

14 Informant

(Address)

*William Bohanan**2528 E 16th Ave**C. H. JOHNSON, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 9 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*2-22-25* to *3-9-28*that I last saw him alive on *3-9-28*and that death occurred on the date stated above, at *4300* m.

The CAUSE OF DEATH\* was as follows:

*Acute Myocardial Infarction*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Acute Cardiac Dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of *3-9-28*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Wm. Bohanan*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

*3-9-28**1400 N. Holladay St.**Wm. Bohanan*

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Baltimore City*

20 UNDERTAKER

*William Bohanan**502 E. North*

R 10 1928



E 31470

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31470

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE, No. 1406 Canal ST. 21-28 WARD

## 2. FULL NAME

(a) RESIDENCE No. 1406 Canal

(Usual place of abode)

Length of residence in city or town where death occurred

life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Brn

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 1-1929

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

m

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Lawrence E. Hawthorne

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MARDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

Luis Hawthorne 1406 Canal St

15

Filed

C. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 9, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1928, to March 9, 1928,

that I last saw him alive on March 9, 1928, and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Primary)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? m Date of

Was there an autopsy? m

What test confirmed diagnosis?

(Signed) J. E. Ladd, M. D.

, 19 (Address) 703 E. 1st St

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Auburn Bur March 10, 1928

20 UNDERTAKER

ADDRESS 916

Samuel E. E. E. E.

Ba me

Physician should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

E 31471

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31471

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2358 M<sup>c</sup>ulloh* ST. *13-54* WARD)2-FULL NAME *Wm. H. Hughes*(a) RESIDENCE NO. *2358 M<sup>c</sup>ulloh* ST.

(Usual place of abode)

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *20* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *C*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Hannah J. Hughes*6 DATE OF BIRTH (month, day, and year) *1863*

7 AGE

Years *65-*

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Painter*(b) General nature of industry, business, or establishment in which employed (or employer) *070*

(c) Name of employer

9 BIRTHPLACE (city or town) *MD*  
(State or country)10 NAME OF FATHER *Dennis Hughes*11 BIRTHPLACE OF FATHER (city or town) *MD*  
(State or country)12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) *?*  
(State or country)

14

Informant (Address) *Amelia H. Hughes (son)*  
*2358 M<sup>c</sup>ulloh*

15

File *10 1328*, 19 *28*

HAMPSON, JAMES M. C. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/10* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *3/22*, 19 *28*, to *3/10*, 19 *28*, that I last saw him alive on *3/9*, 19 *28*.and that death occurred, on the date stated above, at *3 A* m

The CAUSE OF DEATH\* was as follows:

*Ch. Nephritis as a. Colitis.*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Brant Clutter*, M. D.*3/10*, 19 *28* (Address) *2134 D St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOYAL *St. Zion Church**March 10, 1928*

20 UNDERTAKER

ADDRESS *916**Daniel Carter**6a ml*

Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

R 10

E 31472

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31472

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 653 George St.

2. FULL NAME Elliot McDaniels Gibbs.

(a) RESIDENCE NO. 653 George St.  
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 12 ds.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

Negro.

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Lorraine Gibbs.

6 DATE OF BIRTH (month, day, and year)

Oct 27th. 1896

7 AGE

Years  
31Months  
3Days  
11If LESS than  
1 day. hrs  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Lab.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Enamel Wks.

(c) Name of employer Stand. San. Mfg. Cp.

9 BIRTHPLACE (city or town)  
(State or country)

Waylord N.C.

10 NAME OF FATHER

Elija Gibbs

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

N.C.

14

Informant  
(Address)

Lorraine Gibbs (Wife)

15

Date of death

653 George St.  
HARRISON JONES, M.D.

Registrar

ST. WARD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-8-

17

I HEREBY CERTIFY, That I attended deceased from  
March 8th. 1928 to March 8th. 1928that I last saw him alive on March 8th 1928  
and that death occurred, on the date stated above, at 7:45 m.

The CAUSE OF DEATH\* was as follows:

Acct. Fulminating Appendicitis

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 2 ds.

Peritonitis

18 Where was disease contracted  
if not at place of death?

At place of death

Did an operation precede death? NO Date of

Was there an autopsy? NO.

What test confirmed diagnosis? Physical Exam.

(Signed)

Walter J. Jackson

19

(Address)

1631 W. Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

Washington &amp; Co. March 10, 1928

ADDRESS

916  
Og me

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

E 31473

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31473

## CERTIFICATE OF DEATH. X 101

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balt City Hospital 26-37* WARD)2-FULL NAME *Shamus White*(a) RESIDENCE NO. *1229 North St Philadelphia*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*m*

4 COLOR OR RACE

*col*

5 Single, Married, Widowed, or Divorced, (write the word)

*married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*New Jersey*

10 NAME OF FATHER

*Worsey White*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*N. J.*

12 MAIDEN NAME OF MOTHER

*Fannie*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*N. J.*

14

Informant (Address)

15

MAR 10 1928

G. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-7-28*

17

I HEREBY CERTIFY, That I attended deceased from

*213-1928 to 3-7-1928*that I last saw him alive on *3-7-1928*and that death occurred, on the date stated above, at *2:00 p.m.*

The CAUSE OF DEATH\* was as follows:

*Labor Pneumonia Left*

CONTRIBUTORY (Secondary)

(duration) *subacute* mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Home*Did an operation precede death? *yes* Date of *3-14-28*Was there an autopsy? *no*What test confirmed diagnosis? *X-ray*

(Signed)

, 19

(Address)

*Blaylock, M. D. Balt City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health.

ADDRESS

MAR 10 1928



E 31474

HEALTH DEPARTMENT—CITY OF BALTIMORE 31474

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Simai Hospital* ST. *70-1* WARD)2-FULL NAME *Mrs. Margaret Schenberger*(a) RESIDENCE NO. *1015 S. Bouldin* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Philip Oskar Schenberger*6 DATE OF BIRTH (month, day, and year) *July 20 - 1867*7 AGE Years Months Days *66 7 17* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.*  
(State or country)10 NAME OF FATHER *Christian Hattel*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Reister*13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)14 Informant *Philip O. Schenberger*  
(Address) *1015 S. Bouldin St. Baltimore, Md.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/8* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *3/3/28*, 19 to *3/5/28*, 19 that I last saw her alive on *3/5/28*, 19and that death occurred, on the date stated above, at *1:00 P.m.*The CAUSE OF DEATH\* was as follows:  
*Myocardial Failure*CONTRIBUTORY (Secondary) *Incarcerated Unb. Heroin*  
(duration) yrs. mos. ds. *17*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical Exam*(Signed) *Arthur Rude* M. D., 19 (Address) *Simai Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oaklawn Cemetery**3/12* 19 *28*

UNDERTAKER

ADDRESS

*George W. Zinkler**1737 E. Paget St.*

MAR 10 1928

Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

E 31475

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31475

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3900 Ayrdale Ave* ST. *15-63* WARD)

## 2-FULL NAME

*Ella May Boeman*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*3900 Ayrdale Ave*

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Michael A. Boeman*6 DATE OF BIRTH (month, day, and year) *Oct. 25-1870*

## 7 AGE

Years  
*57*Months  
*4*Days  
*13*If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md.*

## 10 NAME OF FATHER

*Geo. W. Blazey*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore, Md.*

## 12 MAIDEN NAME OF MOTHER

*Caroline W. Simon*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore Md.*

## 14

Informant

*Michael A. Boeman*

(Address)

*3900 Ayrdale Ave*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 9 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*1926*, to *Mar. 9*, 19*28*.that I last saw *her* alive on *Mar. 8*, 19*28*.and that death occurred, on the date stated above, at *9 a. m.*

The CAUSE OF DEATH\* was as follows:

*Ch. Valvular Disease of Heart.  
Mitral Insufficiency*(duration) *2+* yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) *2+* yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*Chinensis Laboratory*(Signed) *W. J. Menger*, M. D., 19 (Address) *1015 Apple Tree*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Loudon Park Cem*

## DATE OF BURIAL

*9/2/1928*

## 20 UNDERTAKER

*George W. Jukler*

## ADDRESS

*1737 E. Egan St.*

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 10 1928

C. HAMMON JONES, M.D.

P.M.

Registrar

E 31476

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31476

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1011 Carlton* *16-23* WARD)2. FULL NAME *James Edward Stevenson*(a) RESIDENCE NO. *1110 Carlton*

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Colored**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 31 1926*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**5**8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore**Md*10 NAME OF FATHER *George Stevenson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore**Md*12 MAIDEN NAME OF MOTHER *Josephine Lawson*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore**Md*

14

Informant (Address)

*Josephine Stevenson**1110 Carlton**C. HAMILTON JONES, Jr.*

Filed

MAR 10 1928

Pm

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 9 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 7 1928* to *Mar 9 1928*.that I last saw him alive on *Mar 7 1928*.and that death occurred, on the date stated above, at *2 A. m.*

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*William F. Fry*

M. D.

3/9, 1928 (Address)

*1928 Pa. Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Auburn Cemetery**3/12 1928*

UNDERTAKER

ADDRESS

*Thomas G. Nelson**302*  
*Priestman*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

E 31477

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31477

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

JOHNS HOPKINS HOSPITAL

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George Rey*(a) RESIDENCE NO. *2692 Wilkens Ave.*

(Usual place of abode)

Length of residence in city or town where death occurred

*46* yrs. *10* mos. *16* ds.

Now long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Theresa Rey*

6 DATE OF BIRTH (month, day, and year)

*4-23-81*

7 AGE

*46*

Years

Months

*16*

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Butcher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*George Rey*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ind.*

12 MAIDEN NAME OF MOTHER

*Caroline?*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ind.*

14

Informant (Address)

*Rebecca Theresa Rey 2692 Wilkens Ave.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 7 1928*

17

I HEREBY CERTIFY, That I attended deceased from *3/3*, 1928, to *3/7*, 1928.that I last saw him alive on *3/7*, 1928.and that death occurred, on the date stated above, at *8:05 P. m.*

The CAUSE OF DEATH\* was as follows:

*mastoiditis, bilateral*(duration) yrs. *7* mos. ds.

CONTRIBUTORY (Secondary)

*meningitis*(duration) yrs. mos. *2* ds.

18 Where was disease contracted

if not at place of death?

*unknown*Did an operation precede death? *yes* Date of *3/4/28* *3/6/28*

Was there an autopsy?

What test confirmed diagnosis? *operation, x-ray, spinal fluid*

(Signed)

*L. M. Poley*

M. D.

*3/8, 1928* (Address) *Johns. Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Landon Park Cemetery**March 10 1928*

UNDERTAKER

ADDRESS

*W. H. Hefner, 1850 N. Race St.*

Information should be carefully supplied. AGE should be stated EXACTLY. THIS SPACE SHOULD BE USED FOR STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 10 1928

JOHNS HOPKINS HOSPITAL

Registrar



E 31478

## HEALTH DEPARTMENT—CITY OF BALTIMORE 31478

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2195 Mount* ST. *14-27* WARD)2-FULL NAME *Samuel Cromwell*(a) RESIDENCE NO. *2195 Mount*  
(Usual place of abode)Length of residence in city or town where death occurred *68* yrs. *5* mos. *25* ds.

ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 Single, Married, Widowed,  
or Divorced, (write the word)*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Eliza Cromwell*

6 DATE OF BIRTH (month, day, and year)

*Sept 12, 1859*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*68**5**25*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Painter*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*John Cromwell*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Baltimore*

12 MAIDEN NAME OF MOTHER

*Sarah A. Griffin*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore*

14

Informant  
(Address)*Mrs. Sarah Taylor*  
*2195 Mount St.*

15

*C. HAMPSON JONES, M. D.**RKS*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 8, 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Jan 3, 1928* to *March 8, 1928*,  
that I last saw him alive on *March 8, 1928*,  
and that death occurred, on the date stated above, at *6:15 P. M.*

The CAUSE OF DEATH\* was as follows:

*Mitral Heart Disease*(duration) yrs. *2* mos. *5* ds.CONTRIBUTORY  
(Secondary)(duration) yrs. *Unknown* mos. *Unknown* ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *M. D. O'Neil*, M. D.3/9, 1928 (Address) *108 N. Fulton St.*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Louisa Park**March 12, 1928*

20 UNDERTAKER

ADDRESS *161**George J. Smith**Hollins*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10 1928

# *Howard Brown* HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31479

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31479

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *6000 at Hosp* St. *16-22* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *Ham & Grace* St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. *2* ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *C* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Mar. 7, 1914*7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. *14*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER *Serge Brown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER *Paul Brown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## PARENTS

14 Informant (Address) *Paul Brown*  
*Ham & Grace St.*15 Filed *C. HAMPTON JONES, M. D.* Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 7- 1928*

17 I HEREBY CERTIFY That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

Wherein and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*acc. to 2 & 3 Dr. gm.*CONTRIBUTORY (duration) yrs. mos. ds. *acc. to Hepatitis*  
*10/28* (Address) *143 N 13rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*St. Stephen's ant. Mar. 9, 1928*20 UNDERTAKER ADDRESS *Mrs. R. G. Elliot ashland*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 10 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31480

E 31480

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 721. Curtis Ave. Curtis ST. 25-77 WARD 129)

2. FULL NAME Maryanna Kiluk

(a) RESIDENCE No. 721. Curtis Ave  
(Usual place of abode)

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 21. 1863

7 AGE 65 Years Months Days 13 If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland  
(State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Poland  
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland  
(State or country)14 Informant Martha Palajaska  
(Address) 21 Curtis Ave15 Filed 10-19-28 C. HAMMON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 26, 1925, to March 8, 1928.

that I last saw her alive on March 8, 1928.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex. Thompson

(Signed) M. Thompson M. D.

1925 (Address) 1705-7 E Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Cross Cem. A.A.Co.

March 12 1928.

20 UNDERTAKER

ADDRESS

George A. Weber 9203 Bank St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31481

## CERTIFICATE OF DEATH.

129 E 31481

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 E Randall ST. 24-34 WARD)2-FULL NAME Ernest A. Hartung(a) RESIDENCE NO. 500 E Randall ST. 24-34 WARD

(Usual place of abode)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara C. Hartung6 DATE OF BIRTH (month, day, and year) 4/26/18517 AGE Years 76 Months 10 Days 13 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER Chas Hartung11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Do - not - know13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

## 14

Informant Mrs Louise Klug (Address) 500 E Randall St

Filed

MAR 11 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1928

17

I HEREBY CERTIFY That I attended deceased from Apr. 18 1927 to Mar 8 1928 that I last saw him alive on Mar 8 1928and that death occurred, on the date stated above, at 5-4 m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis(duration) unknown mos. ds.CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? urinal.(Signed) Wm. T. Deary M. D.3/9, 1928 (Address) 636 York Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Louisa Park

DATE OF BURIAL

3/12 1928

20 UNDERTAKER

John J. Faber & Son 1318 Light



E 31482

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31482

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4407 Groveland St. 92 Ward)

Registered No. ....

## 2-FULL NAME

(a) Residence No. ....

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 6 mos. 0 ds.

ds

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

White

## 5-Single,

Married,

Widowed,

or Divorced,

(Write the word)

5a-If married, widowed, or divorced

HUSBAND of (or) WIFE of

Columbia R. Kelley

6-DATE OF BIRTH (month, day and year)

Mar. 20 1857

## 7-AGE.

75 yrs. 11 mos. 9 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

Retired

9-BIRTHPLACE (city or town), (State or Country).

Ga.

## PARENTS.

## 10-NAME OF FATHER.

James W. Kelley

## 11-BIRTHPLACE OF FATHER (city or town), (State or Country).

Ga.

## 12-MAIDEN NAME OF MOTHER.

Amy Hubbard

## 13-BIRTHPLACE OF MOTHER (city or town), (State or Country).

Ga.

## 14-

(Informant)

(Address)

Williams D. Kelley  
4407 Groveland Ave.

## 15-

MAR 11 1928

HARRISON JONES, M. D.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

March 9, 28

## 17-

I HEREBY CERTIFY, That I attended deceased from

Jan. 1, 1928, to date of death

that I last saw him alive on March 8, 1928,

and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH\* was as follows:

Death due to pulmonary embolism, a sequel of femoral thrombosis

(Duration) yrs. mos. 9 ds.

## CONTRIBUTORY

(Secondary)

Indefinite (Duration) yrs. mos. ds.

## 18-Where was disease contracted

If not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual test

(Signed) Physician Lee Davis, M. D.

19 (Address) 827 N. Tupper Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19-PLACE OF BURIAL, CREMATION OR

REMOVAL

## DATE OF BURIAL

Brychley Rd

Mar. 11, 28

20-UNDERTAKER

ADDRESS

George R. Schwalbe 2401 E. 11th Ave.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31483

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4-7 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. Chas Av. Balt Highlands St. 4 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ed. Egtz6 DATE OF BIRTH (month, day, and year) March 21- 19077 AGE Years 20 Months 11 Days 18 IF LESS than 1 day...hrs. or...min.8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Metal worker (b) General nature of industry, business, or establishment in which employed (or employer) Ed (c) Name of employer9 BIRTHPLACE (city or town) Balt (State or country)10 NAME OF FATHER Ed. Egtz11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Amos Egtz (Address) Chas Av

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 192817 I HEREBY CERTIFY That I took charge of the remains described above, held on March 28 (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said InquestInquest and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Left arm almost torn off  
Fract. both legs  
Came in contact with bar of 13rd St. trolleyCONTRIBUTORY (Secondary) Amos Egtz(Signed) Ed. Egtz M. D.Address) 1639 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death...yrs.,...mos.,...ds. In the State...yrs.,...mos.,...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hidden Park Date of Burial 3/28/2820 UNDERTAKER Mr Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 11 1928

HARRISON JONES, M. D.  
Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31484

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

6 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

Anna M

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

MAR 11 1928

HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, that I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

The CAUSE OF DEATH\* was as follows:

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## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31485

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *9-47* WARD)2-FULL NAME *Charles E Hudson*(a) RESIDENCE No. *3627 York Road* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 ~~Single, Married, Widowed,~~ *Divorced* (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *unknown*7 AGE Years *56* Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Carpenter/Builder*(b) General nature of industry, business, or establishment in which employed (or employer) *C*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *Ohio*10 NAME OF FATHER *Herbert F Hudson*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Ohio*12 MAIDEN NAME OF MOTHER *Hattie M. Clark*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Ohio*14 Informant *J. Frank Hudson*  
(Address) *11530 Eulaw Place*15 *FILED* *11* *1928* *JONES, R. D.*

E 31485

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/10* 19 *8*17 I HEREBY CERTIFY, That I attended deceased from *3/9/28*, 19 *8*, to *3/10*, 19 *8*, that I last saw him alive on *3/10*, 19 *8*, and that death occurred, on the date stated above, at *7 40 P* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Bluish, Reddening*  
(Signed) *J. E. Jones* M. D., 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*John O Mitchell Sons 1900 Eulaw Place*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 11 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31486

## CERTIFICATE OF DEATH

E 31486

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *2701 Polk*)St. *9-46* Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Vertney*(a) RESIDENCE NO. *2701 Polk*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. *0* mos. *0* ds. How long in U. S. If of foreign birth? *10* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced. (Write the word) *Married*5a If married, widowed or divorced, HUSBAND of (or) WIFE of *James V. Vertney*6 DATE OF BIRTH (month, day, and year) *Mar 10*7 AGE *about 60* Years Months Days IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)10 NAME OF FATHER *Mr. Mannheim*11 BIRTHPLACE OF FATHER (City or town) *Not known*  
(State or country)12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Not known*  
(State or country)14 Informant *Mrs. Bernard Phelan*  
(Address) *2701 Polk*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 10* 19*28*17 I HEREBY CERTIFY, That I attended deceased from *March 3*, 19*28*, to *March 10*, 19*28*, that I last saw her alive on *March 9*, 19*28*, and that death occurred, on the date stated above, at *3 A.*

The CAUSE OF DEATH\* was as follows:

*Aphoplexy*(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *7* da.CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18 Where was disease contracted \_\_\_\_\_

If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? *clinical*(Signed) *J. H. Kimzey*, M. D.  
19 *10* (Address) *2700 North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Baltimore Cemetery**March 13 1928*

20 UNDERTAKER

ADDRESS

*Harry Beck Son**121 E Eager*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 11 1928

C. HAMPSON JONES, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

E 31487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

E 31487

1-PLACE OF DEATH

City of BALTIMORE: (No. *1211 Wilcox* St. *10-14* Ward)

2-FULL NAME

*Mary E. O'Neill*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

*1211 Wilcox*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *9* mos. *20* ds. How long in U. S. if of foreign birth? *34* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 19 1926*

7 AGE Years *1* Months *9* Days *20* IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Balto. Md*

10 NAME OF FATHER

*James P. O'Neill*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Balto. Md*

12 MAIDEN NAME OF MOTHER

*Mary A. McGraw*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ireland*

14

Informant (Address)

*Mrs Mary A. O'Neill 1211 Wilcox St*

15 Filed

*G. HAMMOND JONES, M.D.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*10 28*

*March 10*

17

I HEREBY CERTIFY, That I attended deceased from

*3/1*, 19*28*, to *3/10*, 19*28*.

that I last saw *h. w.* alive on *3/9*, 19*28*.

and that death occurred, on the date stated above, at *3* a. m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia (Pneumonia)*

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

if not at place of death?

Was there an autopsy? \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis?

(Signed) *Dr. James P. O'Neill*, M. D.

(Address) *914 E. Broad*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*St. Mary's Cemetery*

*March 12 1928*

20 UNDERTAKER

ADDRESS

*Henry Stock Ltd*

*13018 Eager St*

MAR 11 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31488

## CERTIFICATE OF DEATH.

91-002 E 31488

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 612 Saratoga St. 4-25 Ward)2-FULL NAME Joseph Chandler(a) RESIDENCE NO. 612 Saratoga St. 4-25 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown 1864

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Jobbing Contractor

9 BIRTHPLACE (city or town)

(State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Annie Russ  
612 W Saratoga St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1928, to March 7, 1928, that I last saw him alive on March 6, 1928, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary)

Cerebral Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

Signed) H. B. McCord, M. D.  
3/10, 1928 (Address) 2005 Druid Hill Av

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Laurel Cmn. Mar. 11 1928

20 UNDERTAKER

ADDRESS 1027John H. Toadorn Rand Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 11 1928

C. HAMPTON JONES, M.D.

E 31489

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31489

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2802 E. Baltimore* ST., *6* WARD)2. FULL NAME *Barbara Goetzke*(a) RESIDENCE NO. *2802 E. Baltimore* ST., *6* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *60* mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Louis F. Goetzke*6 DATE OF BIRTH (month, day, and year) *Jan 29<sup>th</sup> 1866*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*62**1**9**10*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Germany*

10 NAME OF FATHER

*George Huber*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*William Goetzke 2802 E. Baltimore*

Filed

MAR 11 1928

C. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 9 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 8*, 1928, to *March 9*, 1928, that I last saw her alive on *March 9*, 1928, and that death occurred, on the date stated above, at *10:52 P. M.*

The CAUSE OF DEATH\* was as follows:

*Pneumo-pneumonia*(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

*Cardio-vascular-renal* (duration) *2* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *phy. exam*(Signed) *Louis F. Grimmer*, M. D., 19 (Address) *722 N. Kenwood Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Loudon Park**March 12 1928*

UNDERTAKER

ADDRESS

*Frank V. Pipitone 2818 Baltimore*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31490

## CERTIFICATE OF DEATH.

E 31490

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40

ST. 13-49 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1928

17

I HEREBY CERTIFY That I attended deceased from April 29<sup>th</sup> 1927 to March 10<sup>th</sup> 1928.that I last saw ~~her~~ alive on March 8<sup>th</sup> 1928

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH\* was as follows:

Metastatic Cerebral Carcinoma

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Neoplasm of ovary — Operated upon Feb 4 1927

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) J. W. Jones, M. D.

3/10/28 (Address) Medicine Arts Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

E 31491

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-001

E 31491

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 S. Paca ST. 21-29 WARD)2-FULL NAME Mary Elizabeth Hartlove(a) RESIDENCE NO. 1014 S. Paca

(Usual place of abode)

ST., 21-29 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 0 mos. 13 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)FemaleWhiteSingle5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb. 23-1845

7 AGE

Years

Months

Days 16If LESS than  
1 day, hrs  
or min.83013

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

None9 BIRTHPLACE (city or town)  
(State or country)Balto.  
md10 NAME OF FATHER Nesley Hartlove11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Balto.  
md12 MAIDEN NAME OF MOTHER Elizabeth Jary13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Balto.  
md

14

Informant  
(Address)Thos. F. Hartlove  
4014 Hawthorne Ave

15

Filed

MAR 11 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar. 3, 1928, to Mar. 9, 1928,that I last saw him alive on Mar. 8, 1928,and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia(duration) yrs. mos. 6 ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. 4 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? PE(Signed) Thos. F. Hartlove, M. D.3/12, 1928 (Address) 735 21 Fullerton\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

St. OliveMar 12 1928

20 UNDERTAKER

ADDRESS

Wm J. Pickner SonsN. Y. Pa

N. B.—WRITE PLAINLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31492

## CERTIFICATE OF DEATH.

E 31492

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Laurens

ST. 16-22 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

LYDIA C. SCHIERER

(a) RESIDENCE NO. 1725 Laurens

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of G. Frederick Schierer

6 DATE OF BIRTH (month, day, and year) April 15, 1951

7 AGE Years 76 Months 10 Days 24 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER S. Daniel Maier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Gangwehr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant G. Frederick Schierer (Husband) (Address) 1725 Laurens St.

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1928, to March 9, 1928, that I last saw him alive on March 9, 1928, and that death occurred, on the date stated above, at 12.05 p. m.

The CAUSE OF DEATH\* was as follows:

Cardio Renal & Arterio Sclerosis

CONTRIBUTORY (Secondary)

(duration) 2 hrs. — mos. — ds.

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? All

(Signed) J. Thoma Sulson, M. D.

(Address) 1001 N. Zeller Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL

Mar. 12, 1928

UNDERTAKER

Henry Sander &amp; Sons, Inc

ADDRESS

Baltimore St. and Broadway

N. B.—WRITING SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 11 1928 HAMPSON JONES, M. Registrar

E 31493

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31493

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Kenwood Ave.

ST. 6-10 WARD)

2-FULL NAME AUGUSTA WOLFGRAM

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 18 N. Kenwood Ave.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 54 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Wilhelm E. Wolfram

6 DATE OF BIRTH (month, day, and year) October 30, 1838

7 AGE

Years

89

Months

4

Days

10

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Christian Verg

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not Known

14

Informant Mrs. Bessie Wales (Daughter)

(Address) 18 N. Kenwood Ave.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1928

17

HEREBY CERTIFY, That I attended deceased from

Dec 10, 1927, to Mar 10, 1928

that I last saw him live on 3/9/28

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH\* was as follows:

Complications of disease

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Paul's Cemetery

DATE OF BURIAL

March 12, 1928

20 UNDERTAKER

Henry Sander &amp; Sons Inc

ADDRESS  
Baltimore st  
& BROADWAY

MAR 11 1928

Filed

HARRISON JONES, II, Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31494

## CERTIFICATE OF DEATH.

REGISTERED NO.

129 E 31494

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 20021 Lincoln St. 9 WARD)

## 2. FULL NAME

Bessie Jeffries Cullison

## (a) RESIDENCE NO.

20021 Lincoln St.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of

Chad Cullison

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

approx 43

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

King &amp; Queen Co Va

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Bessie Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Ella Bennett (daughter) 1621 Mc Elder St.

Filed

MAR 11 1928

C. H. HARRIS, JR., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 21, 1928, to March 6, 1928, that I last saw him alive on March 5, 1928, and that death occurred, on the date stated above, at 8 A. m. The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency and (also crowded condition of heart due to obesity) (duration) yrs. 2 mos. ds. CONTRIBUTORY (Secondary) Parenchymatous Nephritis &amp; Anasarca (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed)

3/7/28 (Address) 1424 E Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore County

3/11/28

UNDERTAKER

ADDRESS

Robert William 1515 Mc Elder St

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Bks.

E 31495

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 E Federal ST. 9-18 WARD)

2-FULL NAME Frank X. Mc Intyre

(a) RESIDENCE NO. 1110 E Federal ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mrs Rose D. Mc Intyre

6 DATE OF BIRTH (month, day, and year) Feb 14, 1898

7 AGE Years Months Days 40 24 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9, 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 8, 1928 to Mar 9, 1928

that I last saw him alive on Mar 9, 1928

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH\* was as follows:

Dilatation of heart

CONTRIBUTORY (duration) yrs. mos. ds. John Meunier

(duration) yrs. mos. ds. 8

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John B. Sanders, M. D.

, 19 (Address) 1714 N. Leander St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

Mar 13, 1928

20 UNDERTAKER

ADDRESS

Edmund W. Conklin 924 E. Eager St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31496

## CERTIFICATE OF DEATH.

129 E 31496

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3420 E Baltimore ST. 16-27 WARD)

## 2-FULL NAME

Wm Dykman

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

3420 Baltimore ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sophia Dykman

## 6 DATE OF BIRTH (month, day, and year)

Feb 12 th 1848

## 7 AGE

Years

Months

Days 26

If LESS than 1 day, hrs or min.

80

23

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Seaman

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto

## 10 NAME OF FATHER

Don't Know

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

Sophia Dykman 3420 Baltimore

## 15

Filed

MAR 11 1928

HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) March 8 1928

## 17

I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to March 8, 1928, that I last saw him alive on March 8, 1928, and that death occurred, on the date stated above, at 12:00 Noon

## The CAUSE OF DEATH\* was as follows:

Bronchitis - pneumonia (1 day)

Cardio-vascular-renal disease (10 yrs.)

Chronic Bronchitis (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) 10 yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

## Did an operation precede death?

No Date of

## Was there an autopsy?

No

## What test confirmed diagnosis?

Exam of urine, heart, etc.

(Signed) Louis F. Harrison, M. D.

19 (Address) 722 N. Kenwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem

## DATE OF BURIAL

Mar 10 1928

## 20 UNDERTAKER

John Ullrich

## ADDRESS

2008 Orleans.

N. B.—WRITE EXACTLY. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 31497 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31497

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Home.

CITY OF BALTIMORE: (No.

842 W. Pratt St.

ST.

WARD)

2-FULL NAME

Henry Reining.

(a) RESIDENCE NO.

842 W. Pratt St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

8 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White.

5 Single, Married, Widowed,  
or Divorced (write the word)

single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

10/10/1928

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

38 yrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Labour

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto

10 NAME OF FATHER

Peter Keinaig

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ger

12 MAIDEN NAME OF MOTHER

Marg Berlin

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ger

14

Informant  
(Address)Margaret Keinaig  
842 W Pratt

15

Filed

MAR 11 1928

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

31

8-24

ST.

WARD)

ST.

WARD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10. 1928.

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1. 1928, to Mar. 10. 1928.

that I last saw him alive on Mar. 10. 1928.

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Tuberculosis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of --

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam etc.

(Signed) J. H. S. P. M. D.

(Address) 888 N. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Western

DATE OF BURIAL

Mar 12 1928

ADDRESS

3008 Calver

20 UNDERTAKER

John Ullrich

N. B.—WRITE PLAINLY, WITH CARE AND IN THIS SPACE. PHYSICIANS should state  
mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31498

## CERTIFICATE OF DEATH.

90 E 31498  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1315 W 42 St St. 13-57 Ward)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

6a If married, widowed, or divorced

HUSBAND of  
WIFE of

Albert Van Pelt

6 DATE OF BIRTH (month, day, and year)

Mar 11 - 1868

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

59 11 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

North Carolina

10 NAME OF FATHER

J. H. Snowden

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Evelyn A. Morgan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

North Carolina

14

Informant

(Address)

Mrs. Miller  
1315 W 42 St

15

FILER

C. L. JONES, JR.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 9 - 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Heart Failure following  
Exhaustion of Death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Morrison M. D.  
(Coroner)

3/11, 1928 (Address) 3532 Roland St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Marys Hospital Mar 20/28  
20 UNDERTAKER ADDRESS  
W. S. Marshall 3539 Fall Road

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 11 1928

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

May Hrouch.

E 31499

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90 E 31499  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balti City Hospital ST. 5 WARD)

2-FULL NAME

(a) RESIDENCE NO. 26 S. Alameda ST. 5 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. How long in U. S., if of foreign birth? yrs. How long in U. S., if of foreign birth? mos. How long in U. S., if of foreign birth? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced Married (or) WIFE of Geo. G. Hrouch

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE 75 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti.

10 NAME OF FATHER Patrick Smyth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER May Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Wm. H. Rogers

MAR 11 1928 HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9 1928

17 I HEREBY CERTIFY, That I attended deceased from 3/7, 1928, to 3/9, 1928, that I last saw her alive on 3/9, 1928, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH\* was as follows:

General arteriosclerosis  
Ch. Myocarditis  
Myocardial infarction  
Chronic (duration) 1 yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) R. M. Nichols, M. D.

, 19 (Address) Balti City Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Vincent's Cemetery 3/13 1928

UNDERTAKER Chas. P. Waver & Son ADDRESS 118 Mt Royal Ave



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

31501 HEALTH MAR. 11 Y OF BALTIMORE  
PLACE OF DEATH *Kerran Hospital*  
CITY OF BALTIMORE (No. *Hilldale, Baltimore or d.* ST. *6* WARD)  
FULL NAME *Richard Sheffler*  
(Residence in Baltimore: No. *Waynesboro Pa.* St. yrs. *8* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, *Single*  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)  
6-DATE OF BIRTH *Feb 23*, 1921  
(Month) (Day) (Year)  
7-AGE *18*  
*7* yrs. *17* mos. *17* ds. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

9-BIRTHPLACE  
(State or country)

*Waynesboro Pa.*

PARENTS

10-NAME OF FATHER

*Wesley Sheffler*

11-BIRTHPLACE OF FATHER  
(State or country)

*Franklin Co. Pa.*

12-MAIDEN NAME OF MOTHER

*Ella Anderson*

13-BIRTHPLACE OF MOTHER  
(State or country)

*Adams Co. Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Wesley Sheffler*

(Address)

*Waynesboro Pa.*

15.

MAR 11 1928

HARRISON JONES, M. D.

REGISTRAR

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*March 11*, 1928  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 1*, 1928, to *March 11*, 1928 that I saw him alive on *March 11*, 1928, and that death occurred, on the date stated above, at *9:30* am. The CAUSE OF DEATH\* was as follows:

*Tuberculous Meningitis Complicating Pott's Disease*

(Duration) yrs. mos. ds.

Contributory *Expansion*  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *Clement R. Morris* M. D.

*March 11*, 1928 (Address) *Kerran Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

*Green Hill Cemetery*

DATE OF BURIAL

*3/13*, 1928

20-UNDERTAKER

*H. E. Grace*

ADDRESS

*Waynesboro Pa.*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31502

CERTIFICATE OF DEATH

REGISTERED NO.

E 31502

1-PLACE OF DEATH

City of BALTIMORE: (No. 1417 Riverside ave St. 24-32 Ward)

2-FULL NAME

Catherine Morse

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1417 Riverside ave St. 24-32 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Thos. E. Morse

6 DATE OF BIRTH (month, day, and year)

Oct. 13, 1869

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

58

4

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

039

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Md.

10 NAME OF FATHER

George Van Hagen

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Europe

12 MAIDEN NAME OF MOTHER

Clare Line

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Europe

14

Informant (Address)

Sadie Morse (Daughter)  
1417 Riverside Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 8<sup>th</sup> 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1928, to March 8, 1928, that I last saw her alive on March 8, 1928.

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Crohn's disease

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(duration) \_\_\_\_ yrs. 3 mos. \_\_\_\_ ds.

18 Where was disease contracted

If not at place of death? \_\_\_\_

Did an operation precede death? \_\_\_\_ Date of \_\_\_\_

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) J. H. M. D.

3/10, 1928 (Address) 1417 Riverside Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cem

Date of Burial

March 11, 1928

20 UNDERTAKER

Margaret L. Lynn

ADDRESS

1417 Riverside Ave

MAR 11 1928

E 31503

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balth. City Hospital*)2-FULL NAME *Phillip T. Jones*(a) RESIDENCE NO. *39 E. Hill*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 31503

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1870*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Same*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Va.*10 NAME OF FATHER *Ben. Teager*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va.*12 MAIDEN NAME OF MOTHER *Evelyn Jones*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va.*

14

Informant (Address) *Dr. J. L. Jones*

MAR 11 1940 HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 8 1928*

17

I HEREBY CERTIFY, That I attended deceased from *1/14*, 19*27*, to *Mar 8*, 19*28*.that I last saw him alive on *Mar 8*, 19*28*.and that death occurred, on the date stated above, at *9.15 P. m.*

The CAUSE OF DEATH\* was as follows:

*Epilepsy of Speech*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death? *No*Did an operation precede death? *No*

Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Clinical findings*(Signed) *R. M. Jones*

M. D.

, 19 (Address) *Balth. City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31504

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH 806 N. Kenwood Ave.

CITY OF BALTIMORE: (No. 7-12 ST., WARD)

2. FULL NAME Wm. J. Handlin

(a) RESIDENCE NO. 806 N. Kenwood Ave.  
(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 4 mos. 20 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced. (write the word) single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1926

7 AGE Years 1 Months 4 Days 20 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER John Handlin

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Anna Lupinski

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.  
(State or country)

14

Informant John Handlin  
(Address) 806 N. Kenwood Ave.

MAR 12 1928

HARRISON JONES, M. D.  
Registrar

E 31504

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1928, to March 10, 1928.

that I last saw him alive on March 9, 1928, and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. C. Schibhal, M. D.

, 19 (Address) 447 N. Kenwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 31505**

## CERTIFICATE OF DEATH.

159-002  
**E 31505**  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 925 N Hollington St. 7-12 Ward)2-FULL NAME Albert Payer Jr.(a) RESIDENCE NO. 925 N Hollington St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

Infant

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 7/28

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

2

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)Albert Payer  
925 N Hollington

15

Filed

MAR 12 1928  
HARRISON JOHNS, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

March 9, 1928, to March 11, 1928,

that I last saw him alive on March 11, 1928,

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH\* was as follows:

Sudden Congenital Heart Disease

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

Myocardial Failure

(duration) ..... yrs. .... mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

, 19

(Address)

Joseph Tokorny, M. D.  
2200 E Madison St\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Holy Redeemer

March 11 1928

20 UNDERTAKER

ADDRESS

Muel Brockson

1406 Calhoun

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31506

## CERTIFICATE OF DEATH.

31 ✓ E 31506

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 513 N. Eden St., 5-9 Ward)

## 2-FULL NAME

Norman White

## (a) RESIDENCE NO.

513 N. Eden

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

W.

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

May 1902

## 7 AGE

26 Years10 Months0 DaysIF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore

## 10 NAME OF FATHER

George Albert White

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Janette Cooper

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

## 14

Informant  
(Address)Mrs. Janette White  
513 N. Eden St.

## 15

2 1928 C. HAMPTON JONES, M.D.  
R. H. Jones Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

March 8 1928

## 17

I HEREBY CERTIFY, That I attended deceased from  
Jan 1, 1928, to March 8, 1928,  
that I last saw him alive on March 7, 1928,  
and that death occurred, on the date stated above, at 6:45 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 3 yrs. 0 mos. 0 ds.

## CONTRIBUTORY

(Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

## 18 Where was disease contracted

If not at place of death?

unknown

## Did an operation precede death?

no

Date of

## Was there an autopsy?

no

## What test confirmed diagnosis?

(Signed)

Physical  
R. H. Jones

M. D.

3/9. 1928 (Address) 1428 G. Monument  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Asbury Cemetery3-19-28

## 20 UNDERTAKER

ADDRESS

Mrs. Leona H. Bailey 1428 Jefferson

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31508

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1632 McElderry St St. 74 Ward)

## 2-FULL NAME

John. Sturdivant

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 1632 McElderry St St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred unk mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie Sturdivant

6 DATE OF BIRTH (month, day, and year)

Oct 1/18967 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
31 5 8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....  
(State or country) Chesterfield, S.C.10 NAME OF FATHER Wm. Sturdivant11 BIRTHPLACE OF FATHER (city or town).....  
(State or country) N.C.12 MAIDEN NAME OF MOTHER Lucy Radcliff13 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) S.C.14 Informant Wilbert Sturdivant  
(Address) 1632 McElderry St15 Filed 12-12-28 W. H. JONES Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to his death  
(Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Cerebral Softening.(Glioma(Rt) Cerebrum removed July/27

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)(Signed) J. H. Jones M. D.  
(Coroner)3/11/28 (Address) 500 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

National Cemetery Mar. 12 192820 UNDERTAKER ADDRESS  
Chris. H. Johnson

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 31509 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 31509

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 628 N Eden ST.)

2-FULL NAME Bertrude Hopkins

(a) RESIDENCE NO. 628 N Eden (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25-1912

7 AGE Years Months Days 15 2 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Luther Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Bertrude Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Bertrude Hopkins 628 N. Eden St.

15 C. HARTSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1928

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1928, to March 10, 1928, that I last saw her alive on March 9, 1928, and that death occurred, on the date stated above, at 9 m. The CAUSE OF DEATH\* was as follows:

Acute Cerebral Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician (Signed) M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

20 UNDERTAKER Address

Chas. N. Johnson 416 N. Caroline St.

Filed 12 1928



31510

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Registered No. 31510

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 934 E. Madison St.)

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Baby Thomas

(a) Residence No. 934 E. Madison St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

Colored

## 5-Single, Married, Widowed, or Divorced, (Write the word)

Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar 8-1928

## 7-AGE.

If LESS than 1 day.

yrs. mos. ds.

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore

(State or Country), Md

## 10-NAME OF FATHER.

John F. Thomas

## 11-BIRTHPLACE OF FATHER (city or town).

Charles County

(State or Country), Md

## 12-MAIDEN NAME OF MOTHER.

Lardy Mapp

## 13-BIRTHPLACE OF MOTHER (city or town).

Ticonderoga County

(State or Country), Md

## 14-

(Informant) John F. Thomas

(Address) 934 E. Madison St.

## 15-

Filed

MAR 12 1928

W. HAMPTON JONES, Jr.

Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 9-1928

17- I HEREBY CERTIFY, That I attended deceased from Mar 8, 1928, to Mar 9, 1928,

that I last saw him alive on Mar 8, 1928,

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH\* was as follows:

Premature birth

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

3-9-1928 (Address) 822 N. Bond St.  
\*State the Disease causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL.

Ashbury Cemetery, March 10, 1928

20-UNDERTAKER. ADDRESS

Clara A. Johnson, 414 N. Caroline St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31511

## CERTIFICATE OF DEATH

90 E 31511

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4134 Wilkens Ave., 25-70 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Taylor

(a) RESIDENCE NO. 4134 Wilkens Ave., St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of Laura I. Taylor (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 1863

7 AGE Years Months 10 Days 27 IF LESS than 1 day...hrs. or...min.. 64 II 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

10 NAME OF FATHER Irvin Taylor

11 BIRTHPLACE OF FATHER (City or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Adams

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Laura I. Taylor (Address) 4134 Wilkens Ave.

15 Filed 12 1928 C. HAMPSON JONES, R. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 Mch 9

17 I HEREBY CERTIFY, That I attended deceased from Mch 8, 1928, to Mch 9, 1928

that I last saw him alive on Mch 9, 1928 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH\* was as follows: acute indigestion

CONTRIBUTORY (duration) yrs. mos. ds. prob. fatty heart (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) 3/10 1928 (Address) 1529 W. Lombard St. Registrar

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Cedar Hill Cemetery

March 12/28

20 UNDERTAKER

1531 ADDRESS

Harry W. Witke 1531 W. Lombard St.

N. B.—WHILE FILING, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 12 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31512

## CERTIFICATE OF DEATH.

E 31512

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Woman's Hospital* ST. *14-70* WARD)2-FULL NAME *Miss Mary Dalton Winchester*(a) RESIDENCE NO. *Bellaire Md.*

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

yrs. *8* mos. *24* ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 11/1858*7 AGE Years *69* Months *6* Days *29* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.* (State or country)10 NAME OF FATHER *James Winchester*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Smith*13 BIRTHPLACE OF MOTHER (city or town) *Waterford Ireland* (State or country)14 Informant *Mr. W. C. Howard* (Address) *1115 St Paul St.*15 Filed *1928* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *17* *18* *19* *20* *21* *22* *23* <





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31514

## CERTIFICATE OF DEATH.

90. E 31514

## 1-PLACE OF DEATH

City of BALTIMORE (No. 2716 St. Paul St. 17-50 Ward)

2-FULL NAME Samuel Knox Polk Downey

(a) RESIDENCE NO. 2716 St. Paul St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED, NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of Ella B. Downey (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24 1852

7 AGE Years 75 Months 9 Days 14 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

## 10 NAME OF FATHER John Downey

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)

12 MAIDEN NAME OF MOTHER Susanna Warlick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)

14 Informant Mrs. Ella B. Downey (Address) 2716 St. Paul St.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (inquest, autopsy, or inquiry) thereon and from the evidence obtained by said inquest, autopsy or inquiry, that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Coronary Disease of Heart (duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) John J. Morrison, M. D. (Coroner)

(Address) 3832 Polk Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death!

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park Cem Mar 12, 28

20 UNDERTAKER ADDRESS

Wm. J. Kuer Sons North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 12 1928

## E 31515 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

43 E 31515  
 REGISTERED NO. \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD)

2-FULL NAME Francis Wells(a) RESIDENCE NO. 920 Paris Court  
 (Usual place of abode)Length of residence in city or town where death occurred 18 yrs. 0 mos.

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) ?5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) 7 18857 AGE Years 43 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Servant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
 (State or country) Maryland10 NAME OF FATHER Alex. Wells11 BIRTHPLACE OF FATHER (city or town) Maryland  
 (State or country)12 MAIDEN NAME OF MOTHER Josephine Wells13 BIRTHPLACE OF MOTHER (city or town) Maryland  
 (State or country)14 Informant (Address) Records15 Filed MAR 12 1928 HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 / 9 / 192817 I HEREBY CERTIFY, That I attended deceased from Feb. 29, 1928, to Mar - 9, 1928, that I last saw him on Mar. 9, 1928, and that death occurred, on the date stated above, at 6:30 p. m. The CAUSE OF DEATH\* was as follows:Sacoma of mandibles  
Exhaustion metastases  
 (duration) \_\_\_\_\_ yrs. 6 mos. \_\_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? General & Sub.  
 (Signed) C. Holmes Boyd M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Auburn Bur3/12 1928

20 UNDERTAKER

ADDRESS

Samuel Carter916  
Pa me

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31516

901 31516

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. N. W. Center 16th St. 10 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 2921 Edmonson St. Ward 10

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Jennie K. Sevier6 DATE OF BIRTH (month, day, and year) March 19017 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 66 about

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ret. dentist(b) General nature of industry, business, or establishment in which employed (or employer) 031(c) Name of employer I9 BIRTHPLACE (city or town) Greystown (State or country) MD10 NAME OF FATHER Mr. H. Sevier11 BIRTHPLACE OF FATHER (city or town) Queen Anne's Co. Md. (State or country)12 MAIDEN NAME OF MOTHER Emily Clark13 BIRTHPLACE OF MOTHER (city or town) Queen Anne's Co. Md. (State or country)14 Informant Mr. J. Sevier (Address) 2921 Edmonson St.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 - 28 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valv. dis heartSudden (duration) ..... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

18 (Signed) W. J. Sevier (Coroner) M. D., 1928 (Address) 1639 Duway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

at place of death..... yrs. .... mos. .... ds. State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial 1320 UNDERTAKER Geo W Little

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated. See instructions on back of certificate.

MAR 12 1928

J. H. Jones, Jr. Registrar

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 31517  
PLACE OF DEATH  
County Baltimore City  
Village or City Gowanus (No. 531)  
FULL NAME Laban M. Leiter

129 ✓ E 31517  
STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 2748  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>9</u> <u>10</u> <u>1891</u> (Month) (Day) (Year)		
7 AGE <u>36</u> yrs. <u>7</u> mos. <u>2</u> ds. or min. IF LESS than 1 day hrs. min.		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Minister</u> (b) General nature of industry business, or establishment in which employed or (employer)		
9 BIRTHPLACE (State or country) <u>Near Waynesboro. Pa</u>		
PARENTS	10 NAME OF FATHER <u>L. M. Leiter</u>	
	11 BIRTHPLACE OF FATHER <u>Near Waynesboro. Pa</u>	
	12 MAIDEN NAME OF MOTHER <u>Barbara Lester</u>	
	13 BIRTHPLACE OF MOTHER <u>Near Waynesboro Pa</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs Ida M. Leiter  
(Address) Baltimore City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 12 1928  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 3 1928 to March 12 1928, that I last saw him alive on March 11 1928, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH was as follows:  
arteriosclerosis - in lat. nephritis -  
chron myocarditis

(Duration) 2+ yrs. mos. ds.  
Contributory acute cardiac dilatation  
Secondary

(Duration) 2 yrs. mos. ds.  
(Signed) D. W. Bishop M. D.  
March 12 1928 (Address) 50 N Shundan A

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rougged Cemetery DATE OF BURIAL March 5<sup>th</sup> 1928  
20 UNDERTAKER Ces. B. Hoover ADDRESS Smithsburg

MAR 12 1928



E 31518

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31518

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. *1927*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE No. *5294*

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*Life*

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Colored**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Nov. 28-1912*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*15**3**17*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto Md.*

10 NAME OF FATHER

*John Cooper*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Bertie Wilkerson*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Virginia*

14

Informant (Address)

*Bertie Cooper 5294 N. Mount St.*

15

Filed

MAR 12 1928

19 HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 10 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar 9*, 1928, to *Mar 10*, 1928.that I last saw him alive on *Mar 10*, 1928, and that death occurred, on the date stated above, at *1:15 P. m.*

The CAUSE OF DEATH was as follows:

*Acute Pneumococcus Meningitis, following other malarial*(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clin. & Lab. Exam*(Signed) *Louis T. Jarry*, M. D.3/10/28 Address *W. Balto Gen Hosp*

\*State the Disease Causing Death, or in death from Violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St. Ambrose (C)**3/12/28*

20 UNDERTAKER

ADDRESS

*Samuel Hensley 578*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31519

## CERTIFICATE OF DEATH.

E 31519

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *210 W Biddle* ST., *11-24* WARD)

## 2. FULL NAME

*Maggie M Valentine Jackson*

## (a) RESIDENCE NO.

*210 W Biddle*

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *40* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*Col*

## 5 Single, Married, Widowed, or Divorced. (write the word)

*married*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Wm H. Jackson*

## 6 DATE OF BIRTH (month, day, and year)

*Jan 15-18 77*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*51**1**22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Maid.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Richmond Va.*

## 10 NAME OF FATHER

*Joe Valentine*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Richmond Va.*

## 12 MAIDEN NAME OF MOTHER

*Ellie Green*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Richmond Va.*

## 14

Informant  
(Address)*Clarence Valentine  
210 W Biddle*

## 15

Filed

*HARVEY JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 8 19 28*

17

I HEREBY CERTIFY, That I attended deceased from  
*Mar 6 19 28* to *Mar 8 19 28*.that I last saw him alive on *Mar 8 19 28*and that death occurred, on the date stated above, at *1.30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage (Apoplexy)*  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. *2* ds.18 Where was disease contracted  
if not at place of death? *home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*Mar 8 19 28*  
(Address)*F. C. Jones* M. D.  
*1015 N. E. Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE BURIAL

*St. Andrew's Cem**3/12/28*

## 20 UNDERTAKER

## ADDRESS

*Samuel Hensley*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 12 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31520

## CERTIFICATE OF DEATH.

E 31520

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

MAR 12 1928

C. HARRISON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

July 1st, 1927, to March 11th, 1928.

that I last saw her alive on March 10th, 1928.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Tubercular Meningitis

Myocardial Infarction

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Hypertension

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? to Date of

Was there an autopsy? a

What test confirmed diagnosis? Specimen of tissue

(Signed)

J. A. C. Jones

M. D.

, 19

(Address) 1300 N. Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

J. J. Baker &amp; Sons

1318 Light

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31521

## CERTIFICATE OF DEATH.

E 31521

1-PLACE OF DEATH *St Agnes Hospital*CITY OF BALTIMORE: (No. *Lillie M.*ST. *20-71* WARD)2-FULL NAME *Mrs. Lillie M. Banks*(a) RESIDENCE No. *319 S. Augusta Ave* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos. \_\_\_\_\_ ds. \_\_\_\_\_ How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ (If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Amos Banks*6 DATE OF BIRTH (month, day, and year) *May 1, 1865*7 AGE Years *62* Months *10* Days *8* If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer) *At Home*  
(c) Name of employer \_\_\_\_\_9 BIRTHPLACE (city or town) (State or country) *Baltimore Maryland*10 NAME OF FATHER *Ernest Bracht*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Maryland*12 MAIDEN NAME OF MOTHER *Miss Tuston*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *United States*14 Informant *Amos Banks* (Address) *319 S. Augusta Ave*15 *12 1928* REGISTRAR *RECK*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-9* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *1-16*, 19 *28*, to *3-9*, 19 *28*, that I last saw him alive on *3-9*, 19 *28*, and that death occurred, on the date stated above, at *15:15 P* m.

The CAUSE OF DEATH\* was as follows:

*Gastric Carcinoma*CONTRIBUTORY (Secondary) *General Carcinomatosis*18 Where was disease contracted if not at place of death? *no*Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Ray*(Signed) *Frederick L. Hughes* M. D.319, 128 (Address) *St Agnes Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Baltimore Cemetery*

DATE OF BURIAL

*Mar. 12 1928*20 UNDERTAKER *RECK*

ADDRESS

*1003 West Baltimore St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AR 12 1928



E 31522  
 PHYSICIANS should state  
 Exact statement of OCCUPA-  
 TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *90*)

## 2. FULL NAME

(a) RESIDENCE No. *2791 Alameda Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *59* yrs. *10* mos.

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Male**White**Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Geo. W. Busch*

6 DATE OF BIRTH (month, day, and year)

*Oct 1868*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*59**10**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Housewife*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Bolton*

10 NAME OF FATHER

*Jr. McLaughlin*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Bolton*

12 MAIDEN NAME OF MOTHER

*Mary P. Jones*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Bolton*

14

Informant  
(Address)*Mr. J. P. Jones*

15

Filed

MAR 12 1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 10 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Feb 29*, 1928, to *March 10*, 1928.that I last saw him alive on *March 10*, 1928.

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*Ch. Myocarditis also  
Ep. Houston. Melancholia + Toxicosis  
caused by delusions of Melancholia.*(duration) yrs. *2* mos. ds.CONTRIBUTORY  
(Secondary)*Stupor Depress. Phrenia*  
(duration) *1* yrs. *6* mos. ds.18 Where was disease contracted  
if not at place of death? *unknown*Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Physical + Chemical*(Signed) *William P. Hill* M. D., 19 (Address) *Mr. J. P. Jones*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
SIOVAL

DATE OF BURIAL

*Holy Redeemer**March 19 28*

20 UNDERTAKER

ADDRESS

*Geo. M. Smith & Son**811 N. Ave.*

## CERTIFICATE OF DEATH.

E 31523  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 102 N. Curley St. ST. WARD  
(Usual place of abode)

Length of residence in city or town where death occurred				How long in U. S., if of foreign birth?			
	yrs.	mos.	ds.		yrs.	mos.	ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1949 128

17 I HEREBY CERTIFY, That I attended deceased from  
Mar. 1, 1928, to Mar. 9, 1928  
that I last saw her alive on Mar 8, 1928  
and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Grades Premium in

(duration) ... yrs. mos 10 da

**CONTRIBUTORY**  
(Secondary)

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted  
if not at place of death? .....

Batto.

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis? *Clinical*  
(Signed) *Alvin J. Fisher* M.D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

**20 UNDERTAKER.**

ADDRESS  
3000 E,  
Balto Md

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31524

## CERTIFICATE OF DEATH.

E 31524

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 33261 Raymond Ave WARD)2-FULL NAME Wilhelmina Griller(a) RESIDENCE No. 33261 Raymond Ave  
(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Louis6 DATE OF BIRTH (month, day, and year) Sept 20, 18637 AGE Years 64 Months 5 Days 21 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Germany10 NAME OF FATHER Carl W. Griller11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany12 MAIDEN NAME OF MOTHER Regina Craich13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany14 Informant Mrs. H. Smith  
(Address) 3126 Raymond Ave15 Filed 12-12-28 C. HAMPSON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 192817 I HEREBY CERTIFY That I attended deceased from March 10, 1928 to March 11, 1928that I last saw her alive on March 11, 1928and that death occurred, on the date stated above, at 6-30 am

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. S. Ruben

, 19

(Address) 475 Park Heights

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn HillNov 17 1928

20 UNDERTAKER

ADDRESS

Wm. Cook 502 N. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31525

## CERTIFICATE OF DEATH.

90 E 31525

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1401 W. Lanvale*

ST. *1672* WARD)

### 2-FULL NAME

*Rollins J. Mullikin*

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### (a) RESIDENCE NO.

*1401 W. Lanvale*

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*40* yrs.

— mos. —

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

*Male*

#### 4 COLOR OR RACE

*white*

#### 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

#### 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Grace A. Mullikin*

#### 6 DATE OF BIRTH (month, day, and year)

*Dec. 23-1863*

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*64*

*2*

*17*

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Druggist*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Self*

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

*Maryland*

#### 10 NAME OF FATHER

*Charles E. Mullikin*

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

#### 12 MAIDEN NAME OF MOTHER

*Matilda Smith*

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

#### 14

Informant (Address)

*Grace A. Mullikin 1401 W. Lanvale St*

#### 15

Filed

MAR 12 1928

*H. J. Jones, Jr.* Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

*March 10 1928*

#### 17

I HEREBY CERTIFY, That I attended deceased from *March 9, 1928*, to *March 10, 1928*, that I last saw him alive on *March 10, 1928*, and that death occurred, on the date stated above, at *1130 P* m.

The CAUSE OF DEATH\* was as follows:

*Decompensating Heart with Aortic Sclerosis*

*Unknown* (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) *Unknown* (duration) — yrs. — mos. — ds.

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of —

Was there an autopsy? *No*

What test confirmed diagnosis? *aff* (Signed) *J. H. Nelson*, M. D.

19 (Address) *1007 N. Fulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

#### DATE OF BURIAL

*Woodlawn Cemetery* *March 13 1928*

#### UNDERTAKER

#### ADDRESS

*Chas. E. French* *802 Madison Ave*



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

211982

E 31526

160 E 31526

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. INS HOPKINS HOSPITAL ST. 2-4 WARD)

## 2-FULL NAME

Michael Balke

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

724 S. Belhel

ST.

WARD City

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Md -

## 10 NAME OF FATHER

Pete Balke

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

Annie Palk

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

## 14

Informant (Address)

Records -

## 15

Filed

MAR 12 1928

JAMES HOPKINS HOSPITAL

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar - 8, 1928, to Mar - 10, 1928,

that I last saw him alive on Mar. 10, 1928, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH\* was as follows:

Marasmus

(duration) yrs. 2 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Allen Blalock, M. D.

19 (Address) The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Stanislaus March 12 1928

20 UNDERTAKER

ADDRESS

FW Gzowski 81730

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY how long deceased was ill.

Spec.—1-10-21—M&T—1500 Bks.

E 31527

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 31527

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 S. Rose

ST. 1-3 WARD)

2-FULL NAME John A. Bull, Jr.

(a) RESIDENCE NO. 203 S. Rose  
(Usual place of abode)

ST. 1 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10 1928

7 AGE

Years

Months

Days

If LESS than 1 day 13 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Md.

10 NAME OF FATHER John A. Bull

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Bullock

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Md.

14

Informant John A. Bull, Jr.  
(Address) 203 S. Rose

15

MAR 12 1928

JOHN J. BULL, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1928

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1928 to March 11, 1928, that I last saw him alive on March 11, 1928, and that death occurred, on the date stated above, at 4:30 P. M. The CAUSE OF DEATH\* was as follows:

Blue baby

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. W. Ozarowski, M. D.

2-11-28 (Address) 2701 Eastern

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Stanislaus

March 12 1928

20 UNDERTAKER

ADDRESS

J. W. Ozarowski

1930 Eastern

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST., 7-10 WARD)

2-FULL NAME *Royal Williams*(a) RESIDENCE NO. *525 Patterson Plk. Ave*

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Caucas*

5 Single, Married, Widowed, or Divorced, (write the word)

*Baby*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Infant*6 DATE OF BIRTH (month, day, and year) *Feb. 18 - 1928*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*3 weeks**22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

(c) Name of employer

*None*

9 BIRTHPLACE (city or town) (State or country)

*Ind Baltimore*

10 NAME OF FATHER

*James Williams*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

*Ruby*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ind*

14

Informant (Address)

*Ruby Ruby William 525 Patterson Park Ave*

File

*12 1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 10 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 8, 1928* to *March 10, 1928*, that I last saw him alive on *March 10, 1928*, and that death occurred, on the date stated above, at *6:15* a.m.

The CAUSE OF DEATH\* was as follows:

*Erythrasia - no human lesion - botryoid umbilicus*(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

*Pneumonia*(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *NO* Date ofWas there an autopsy? *yes*

What test confirmed diagnosis?

*Positive blood culture*

(Signed)

*J. J. Bennett*

M. D.

Mar. 1928 (Address)

*Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Asbury Cem*

DATE OF BURIAL

*3/12 1928*

20 UNDERTAKER

*Byron Wright 1218 McGolderry*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31529

## CERTIFICATE OF DEATH

REGISTERED 31529

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 5-8 Ward)2-FULL NAME Charles Downs

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 142 East St St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Black 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) March 19287 AGE Years 10 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Balto. (State or country) Md.10 NAME OF FATHER Samuel Downs11 BIRTHPLACE OF FATHER (City or town) Balto. (State or country) Md.12 MAIDEN NAME OF MOTHER Hillis Wilson13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.14 Informant Samuel Downs, Father (Address) 142 East St15 Filed 1928 U. S. DEPARTMENT OF HEALTH, PUBLIC HEALTH SERVICE, BALTIMORE, MD. Registrar [Signature]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9 192817 I HEREBY CERTIFY, That I attended deceased from 12/21/28 1928 to 3/9/28 1928that I last saw him alive on 3/9/28 1928and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
Tuberculous Peritonitis(duration) 4 yrs. 4 mos. 14 ds.CONTRIBUTORY Partial Intestinal (Secondary) Obstruction(duration) 4 yrs. 4 mos. 14 ds.

18 Where was disease contracted

if not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? yesWhat test confirmed diagnosis? Autopsy(Signed) J. S. Wilson, M. D., 19 28 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Asbury Cem3/12 1928

20 UNDERTAKER

ADDRESS

Brown & Knight, 1218 McElderry St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



E 31530

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31530

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St 4-30 Ward)

## 2-FULL NAME

Robert H. Warren

## (a) RESIDENCE NO.

Laurel, Md

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Dec 1926

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

athome

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Laurel

(State or country)

Md

## 10 NAME OF FATHER

Bryan Warren

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

North Carolina

## 12 MAIDEN NAME OF MOTHER

Jennie Hock

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pa

## 14

Informant  
(Address)University Hospital RecordsC. HAMMON JONES, M.D.Per [Signature] Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to his death  
on the day stated above.  
topsy or inquiry.

The CAUSE OF DEATH\* was as follows:

Burns of face + mouth  
accident(duration) yrs. mos. 3 ds.

## CONTRIBUTORY (Secondary)

Terminal Pneumonia(duration) yrs. mos. 2 ds.(Signed) Eugene J. Jones, M. D.  
(Coroner)8/11, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Md

## Date of Burial

8/13/1928

## 20 UNDERTAKER

Lloyd Kaiser

## ADDRESS

Laurel Md

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 12 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31531

## CERTIFICATE OF DEATH

REGISTERED NO.

E 31531

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 631 S. Mountford Ave St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Smith(a) RESIDENCE NO. 631 S. Mountford Ave St. 1 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Frank W. Smith6 DATE OF BIRTH (month, day, and year) June 20<sup>th</sup> 18527 AGE Years 75 Months 8 Days 12 IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. m. n. e.(b) General nature of industry, business, or establishment in which employed (or employer) housewife(c) Name of employer none9 BIRTHPLACE (city or town) Germany (State or country) not known10 NAME OF FATHER Not known11 BIRTHPLACE OF FATHER (City or town) Germany (State or country) not known12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country) not known14 Informant Augusta G. Smith (Address) 6915 Ridgway Road, Dundalk, Md.15 Filed 7-2-1928 19 1928 Registrar W. H. H. H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 Udd. 8<sup>th</sup>17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1928, to March 8, 1928, that I last saw her alive on March 7, 1928.and that death occurred, on the date stated above, at 4:20 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic bronchitis with cardiac hypertrophy - dilatation  
more than 10 (duration) yrs. mos. ds.CONTRIBUTORY Capillary bronchitis (Secondary) apoplexy (duration) yrs. mos. ds. 7

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. H. H. M. D. 3/10/1928 (Address) 1014 S. Belmont Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Oak Lawn Cemetery Udd. 12<sup>th</sup> 1928  
20 UNDERTAKER Lilly & Ziller Inc. ADDRESS 4000 W. 15<sup>th</sup>

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Exact statement of OCCUPATION is very important See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31532

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

Baltimore City Hospitals (1-3) ST. 1-3 WARD

## 2. FULL NAME

Anna Senseney

(a) RESIDENCE NO.

2725 Dillon st.

(Usual place of abode)

ST. 1

WARD

Length of residence in city or town where death occurred

Unknown

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5c If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1900

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Herman Goodwill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

K. Logenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Hospital Records

15

MAR 12 1928

H. J. JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1928, to March 9, 1928,

that I last saw her alive on March 9, 1928,

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY Tuberculous laryngitis (Secondary)

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical and Lab.

(Signed) J. J. Madden, M. D.

3-9-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cath. Lawn Cemetery

DATE OF BURIAL

Mar 12 1928

20 UNDERTAKER

Lilly &amp; Zuber Inc.

ADDRESS

403 S. Washington

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31533

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31533

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 5746 Oxford St. 17-24 Ward)

## 2-FULL NAME

(A) RESIDENCE NO. 5746 Oxford

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race E. 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henetta Epps6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years 70 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Long Shoreman  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_9 BIRTHPLACE (city or town) VA.  
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) Unknown14 Informant Henetta Epps  
(Address) 5746 Oxford St.

MAR 12 1926

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquiry and that said deceased came to his death on the day stated above.  
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis(duration) \_\_\_\_\_ yrs. mos. ds. 718 PLACE OF BURIAL, CREMATION OR REMOVAL Chapman(duration) \_\_\_\_\_ yrs. mos. ds. 12/28(Coroner) \_\_\_\_\_ M. D. Blades(Address) 143 W. Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Date of Burial 3/12/2820 UNDERTAKER Mrs. R. G. ElliottADDRESS 1725 Ashland



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31534

## CERTIFICATE OF DEATH.

E 31534

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Albemarle ST. WARD)

## 2-FULL NAME Infant Zerk

(a) RESIDENCE NO. 114 Albemarle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 1928

7 AGE

Years

Months

Days

If LESS than 1 day 5 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Alexey Zerk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Domnicola Rolando

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant (Address) Alexey Zerk 114 Albemarle ST.

15

Filed

G. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 11 1928 to Mar 11 1928 that I last saw him alive on Mar 11 1928

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Acute Nephritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. P. Ryan, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Holy Rodene Cem. Mar 12 1928  
Chas. K. Kuchanek, 637 S. Maryland

MAR 12 1928

PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 31535

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals ST. 16-B-72 WARD)2-FULL NAME Nathaniel Eads(a) RESIDENCE NO. 903 Parrish st.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos.ST. 16-B-72 WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 19167 AGE Years Months Days If LESS than 1 day, hrs. or min.  
12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Walter Eads11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Ella Miller13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant (Address) Hospital Records15 Filed 12 1928 C. HARRISON JONES, JR. Registrar

E 31535

REGISTERED NO. 31  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 192817 I HEREBY CERTIFY, That I attended deceased from Feb. 29, 1928, to March 8, 1928, that I last saw him alive on March 8, 1928, and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis.(duration) Unknown yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Clinical and autopsy  
(Signed) W. H. Harrison Jones, Jr., M. D.3-8-1928 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

TION is very important See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31536

## CERTIFICATE OF DEATH.

E 31536

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Not above Hill St. WARD)

## 2-FULL NAME

(a) RESIDENCE No. 217 Broadway St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed 19

Registered

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

17

I HEREBY CERTIFY, that I attended deceased from

3/10, 1928, to 2/10, 1928

that I last saw him alive on 2/10, 1928

and that death occurred, on the date stated above, at 5:30 am.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. G. Ruden, M. D.

3/11/28 (Address) 915 E Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

London Park Mar 14 1928

20 UNDERTAKER

ADDRESS

Wmboof 552 E Fayette

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31537

## CERTIFICATE OF DEATH.

90 E 31537

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2639 Wilkens ST. 70-72 WARD)2-FULL NAME Lula Frankbach(a) RESIDENCE NO. 2639 Wilkens ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of Frank H. Frankbach or WIFE of6 DATE OF BIRTH (month, day, and year) April 27-18777 AGE Years 50 Months 11 Days 13 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)10 NAME OF FATHER Columbus Knight11 BIRTHPLACE OF FATHER (city or town) ind. (State or country)12 MAIDEN NAME OF MOTHER Almira Mills13 BIRTHPLACE OF MOTHER (city or town) ind. (State or country)14 Informant Frank H. Frankbach (Address) 2639 Wilkens15 Filed 12-19-28 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 192817 I HEREBY CERTIFY, That I attended deceased from Mar 8, 19 28, to Mar 10, 19 28.that I last saw him or alive on Mar 10, 19 28and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH\* was as follows:

PneumoniaIndefinite (duration) yrs. mos. ds.CONTRIBUTORY acute cardiac failure (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D. Mar 11, 19 28 (Address) 706 8 7 Mar 11 1928

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Londontown DATE OF BURIAL Mar 13 192820 UNDERTAKER Wm Cook 5028 York ADDRESS

Exact statement of OCCUPATION is very important. See instructions on back of certificates.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 31538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25 E 31538

1-PLACE OF DEATH *Franklin Square Hospital*  
CITY OF BALTIMORE: (No. *Calhoun + Fayette* ST. *16-76* WARD)

2-FULL NAME *Edward Gagen*

(a) RESIDENCE NO. *923 Harlem Ave ST.* WARD

(Usual place of abode)  
Length of residence in city or town where death occurred *3* yrs. • mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. *25 E 31538*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 30, 1919*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*8 10 11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School boy*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Unknown* (State or country)

10 NAME OF FATHER *John Gagen*

11 BIRTHPLACE OF FATHER (city or town) *Unknown* (State or country)

12 MAIDEN NAME OF MOTHER *Lorena Dorman*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *md.*

14 Informant *Margaret W. Dorman* (Address) *923 Harlem Ave*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 11 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Mar 8 1928* to *Mar 11 1928*, that I last saw him alive on *Mar 11 1928* and that death occurred, on the date stated above, at *10:05 P.m.* The CAUSE OF DEATH\* was as follows:

*Acute nephritis with uremia + convulsions*

(duration) yrs. mos. ds. *16*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *Laboratory exam.*

(Signed) *Eliza A. B. Sherrin* M. D.

19 (Address) *Franklin Sq. Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Landon Park*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*William Cook*

*502 E. W. 128*

AR 12 1928 HAMPSON JONES, M. D.

E 31539

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31539

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1007 Bimney St., 1-1 Ward)2-FULL NAME John Gayvor(a) RESIDENCE NO. 1007 Bimney St., 1 WardLength of residence in city or town where death occurred 13 yrs.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 13 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown7 AGE Years 36 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevenson Works

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Poland10 NAME OF FATHER John W. Gayvor

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

## PARENTS

14 Informant Helen Gayvor(Address) 1027 Bimney St.15 Filed 12 1925

16 HARRISON JONES, M. D.

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 192517 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said Inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

M. W. Insanity  
Suicide Hanging  
(duration) 6 yrs. mos. ds.

## CONTRIBUTORY

Mar 10/25 (Signed) G. C. States (duration) 6 yrs. mos. ds.(Address) 143 N. Bimney

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Michael's Church 3-11-25

20 UNDERTAKER ADDRESS

Wesley H. Szwedowski

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 31540

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

E 31540

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Sydenham Hospital St. 4 Ward)

## 2-FULL NAME

Peter Borotko

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

510 S. Daller

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct. 24, 1924

## 7 AGE

Years

Months

Days

1F LESS than  
1 day.....hrs.  
or.....min..3416

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Maryland

## 10 NAME OF FATHER

Leon Borotko

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Mary Zadoga

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## 14

Informant

(Address)

Mrs. Mary Borotko510 S. Daller St.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

March 11, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb. 25, 1928, to March 11, 1928that I last saw him alive on March 11, 1928and that death occurred, on the date stated above, at 7:08 p.m.

The CAUSE OF DEATH\* was as follows:

Diphtheria - Tonsillar and Laryngeal

(duration)

yrs.

mos.

da.

## CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

da.

## 18 Where was disease contracted

If not at place of death?

At home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Bacteriological

(Signed)

J. L. Levin

M. D.

Mar. 12, 1928 (Address)

Sydenham Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy RosaryMarch 12, 1928

## 20 UNDERTAKER

ADDRESS

John M. Weber 4012 Chester

MAR 12 1928

C. H. JONES, Jr.

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31541

E 31541  
REGISTERED NO.City of BALTIMORE: (No. *Little Clinton St.* 10-14 Ward)2-FULL NAME *John C. Neil*(a) RESIDENCE NO. *Preston & Valley* St. WardLength of residence in city or town where death occurred *20* yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 Color or Race *E* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Margaret O'Neill*

6 DATE OF BIRTH (month, day, and year)

1871

7 AGE Years Months Days  
*57* IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER *John C. Neil*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER *Catherine Bailey*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14 Informant *Little Clinton St.*  
(Address) *Preston & Valley St.*15 Filed....., 1928  
MAR 12 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

3/10

1928, to

3/11

1928.

that I last saw him alive on

3/10

1928.

and that death occurred, on the date stated above, at *7 a* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*  
*30 years* (duration) yrs. mos. ds.CONTRIBUTORY *Ordinary*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/11, 1928 (Address) *914 E. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL*Cathedral*

20 UNDERTAKER

*Mar 13 1928*  
ADDRESS*Bila Wiedefeld 914 Greenbelt Ave*

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31542  
1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD)

2. FULL NAME *Frederick Hemilson*(a) RESIDENCE No. *1319 E. Sunland*  
(Usual place of abode)Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
(If non-resident give city or town and State)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of or WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*60*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 BALTIMORE CITY HOSPITALS

Informant (Address) *Records*15 *MAR 12 1928* *FRANKSON JONES, JR.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/12/1928*17 I HEREBY CERTIFY That I attended deceased from *Mar. 2*, 1928, to *Mar. 12*, 1928, that I last saw him live on *Mar. 12*, 1928, and that death occurred, on the date stated above, at *1:30 A. M.*  
The CAUSE OF DEATH\* was as follows:*Hemiplegia - right*  
*arteriosclerosis*  
*hypertension*(duration) yrs. mos. *1* ds.CONTRIBUTORY (Secondary) *Senile dementia*(duration) yrs. mos. *4* ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *General & Sub*(Signed) *C. J. Jones, M. D.*

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Howell Mt. Cemetery*  
UNDERTAKER

DATE OF BURIAL

*3-12-1928*

ADDRESS

*Jack Lewis, 1438 E. Balto.*

TION is very important See instructions on back of certificates.

31543

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

88 E 31543

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2512 Wilkins Ave ST. 70-69 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 2512 Wilkins Ave ST. 70-69 WARD

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 - 277 AGE Years 7 Months 8 Mo Days 28 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Albert H. Reisinger11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Clara J. Matthews13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant Clara Reisinger (Address) 1010 E. Baltimore Ave

15 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 19 2817 I HEREBY CERTIFY, That I attended deceased from February 27, 19 28, to March 11, 19 28, that I last saw her alive on March 11, 19 28, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH\* was as follows:

Conjunctive Endocarditis  
Acute Nephritis  
Hypostatic PneumoniaCONTRIBUTORY (Secondary) Pulmonary Edema (duration) 2 yrs. 10 mos. 1 ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) Dr. H. C. Jones, M. D.19 (Address) 2107 Wilkins Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL March 13 19 2820 UNDERTAKER Wm. Brock S. Finch ADDRESS 2512 Wilkins Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12 1928

E 31544

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31544

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *445 N. Patterson Park St.* ST.,WARD) *47*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Emma C Wright*(a) RESIDENCE NO. *445 N. Patterson Park St.* ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *N*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of or WIFE of *Harry E Wright*6 DATE OF BIRTH (month, day, and year) *July 22 1869*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *58 7 18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*(b) General nature of industry, business, or establishment in which employed (or employer) *031*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Dale Md*10 NAME OF FATHER *Geo. Sanner*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Mary Brockel*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *Harry E Wright 445 N. Patterson Park St.*

15

12 1928

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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 10 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr 1 1927* to *Mar 10 1928* that I last saw him alive on *Mar 10 1928*and that death occurred, on the date stated above, at *5:35 p.m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Edema*(duration) yrs. mos. ds. *Baseline* *Burst* *Remains in* *CONTINUOUS* *(Secondary)* *Chest* *Spine etc* (duration) yrs. mos. ds. *11*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *April 1927*Was there an autopsy? *no*What test confirmed diagnosis? *Symptoms*(Signed) *Alvin Bleuman* M. D.3/11/28 (Address) *718 N. Patterson Park St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Baltimore**Mar 13 1928*

20 UNDERTAKER

ADDRESS

*W. Cook**502 E. North Ave*

E 31545

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31545

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1446 Decatur ST., 24-35 WARD)2-FULL NAME Vincent Weinmann(a) RESIDENCE NO. 1446 Decatur

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds.ST., 24-35 WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 45 yrs. mos. ds.REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE A5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne Weinmann6 DATE OF BIRTH (month, day, and year) Nov 17, 1841

7 AGE

Years 87Months 1Days 24

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria10 NAME OF FATHER John Weinmann11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14

Informant (Address) Louis Weinmann  
1446 Decatur St

15

C. HAMPTON JOHNS, JR., D. O. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 19 28

17

I HEREBY CERTIFY, That I attended deceased from July 2, 19 25, to Mar 10, 19 28.that I last saw him alive on Mar 10, 19 28.and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH\* was as follows:

arterio Sclerosis(duration) 4 yrs. mos. ds.CONTRIBUTORY (Secondary) Cerebral Hemorrhage(duration) yrs. mos. ds. 1

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Typical(Signed) W. H. Thomas, M. D.(Address) 1228 Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REBURYAL DATE OF BURIAL

MOVAL Holy Cross A. A. Church Mar 13 19 28

20 UNDERTAKER

ADDRESS

W. H. Cook 312 E. North Ave

TION is very important. See instructions on back of certificates.



E 31546

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31546

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.

WARD) 17-24

## 2-FULL NAME

Boy Barney

(a) RESIDENCE No.

1344 Druid Hill Ave.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 6, 1928

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

1

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Me

10 NAME OF FATHER

Benjamin Barney

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

Hora Harris

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

Records

15

2 1928

19

JOHNS HOPKINS HOSPITAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Gammeltoner Health.

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 6, 1928, to Mar. 7, 1928,

that I last saw him alive on Mar. 7, 1928,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Malnutrition

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY  
(Secondary)

Dehydration &amp; pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? None

(Signed) J. S. Barner, M. D.

Mar. 7, 1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL MAR 12 1928

ADDRESS

E 31547

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31547

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home & Infirmary*

REGISTERED NO. ....

CITY OF BALTIMORE: (NO. *George Harrison*)ST. *6* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Boy Denny*(a) RESIDENCE NO. *Belair Rd.*

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 13, 1928*

7 AGE Years Months Days If LESS than 1 day 5 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *J. V. Denny*11 BIRTHPLACE OF FATHER (city or town) *Long Island City, N. Y.* (State or country)12 MAIDEN NAME OF MOTHER *Mary Ann Yellow*13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)14 Informant *Mrs. John D. Yellow* (Address) *Belair Rd.*15 *G. HAMPTON JONES, M. D.* Registrar

12 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 13, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 13, 1928*, to *March 13, 1928*, that I last saw him alive on *March 13, 1928*, and that death occurred, on the date stated above, at *7.25 A.M.*

The CAUSE OF DEATH\* was as follows:

*Enlarged Thyroid Gland. Hemorrhage posterior & it.*

(duration) yrs. mos. ds.

CONTRIBUTORY *Asphyxia* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *0* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Yes*(Signed) *W. G. Harrison, M. D.*, 19 (Address) *Church Home & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Mt Zion Haymarket* *Mar 13 1928*20 UNDERTAKER *Dean & Foster* *Belair Md*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31548

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4205 Ridgemoor Ave. ST. 28-65 WARD)2-FULL NAME Frank Feulner(a) RESIDENCE NO. 4205 Ridgemoor Ave. ST. 28-65 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara A. Feulner6 DATE OF BIRTH (month, day, and year) July 12/1849

7 AGE

Years

Months

Days

78728

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany10 NAME OF FATHER Conrad Feulner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Lily W. Feulner  
4205 Ridgemoor Ave.

15

File

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Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 5, 1928, to Mar 11, 1928,that I last saw him alive on Mar 10, 1928,and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH\* was as follows:

Bronchial pneumonia(duration) 6 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) 6 yrs. 6 mos. 6 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

A. C. Smith

M. D.

(Address)

4209 Schuyler Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

London Park CemeteryMar 14 1928

20 UNDERTAKER

ADDRESS

Harry H. Amason 4205 Ridgemoor Ave

Exact statement of occupant. See instructions on back of certificates.

E 31549

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31549

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6102 Parkheights Ave. ST. 27-55 WARD)

2-FULL NAME Mary Ella Hoffman

(a) RESIDENCE No. 6102 Parkheights Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Hoffman

6 DATE OF BIRTH (month, day, and year) April 22 1852

7 AGE Years 75 Months 10 Days 17 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co. Md. (State or country)

10 NAME OF FATHER William G. McGinniss

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Mary ANN Sipes

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Mrs. Frank E. Bailey (Address) 6102 Parkheights Ave.

15 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March, 10th 1928

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to March 10, 1928, that I last saw her alive on March 10, 1928, and that death occurred, on the date stated above, at 7.26 P. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S. Tibbitt M. D.

3/11, 1928 (Address) 2220 Garrison Avenue.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Mt Olive Cem (Panda) town Mar. 13, 28

20 UNDERTAKER

ADDRESS

100.3/11 Date SA

Exact statement of O. C. G. U. P. A. TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31550

## CERTIFICATE OF DEATH

31 E 31550

## 1-PLACE OF DEATH

City of BALTIMORE: (No. I22 S Mount St., 19-28 St., 19-28 Ward)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A. Holtman,(a) RESIDENCE NO. I22 S Mount St., St. 19-28 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Helen C. (Nee Linsenmeyer)6 DATE OF BIRTH (month, day, and year)  
August 25, 18937 AGE Years 34 Months 5 Days 14 IF LESS than 1 day, hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk(b) General nature of industry, business, or establishment in which employed (or employer) B. & O.

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Md.10 NAME OF FATHER Frank J. Holtman11 BIRTHPLACE OF FATHER (City or town)  
(State or country) Md.12 MAIDEN NAME OF MOTHER C. Hentze.13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Md.14 Informant Mrs. Helen C. Holtman(Address) I22 S. Mount St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/28 1917 I HEREBY CERTIFY, That I attended deceased from 1/27/28, 19, to 3/10/28, 19that I last saw him alive on 3/10/28, 19and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Cut ThroatCONTRIBUTORY  
(Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? usual(Signed) Henry A. Holtman, M. D.3/10/28 (Address) 410 W. Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

New Cathedral Cemetery March 13, 1928  
20 UNDERTAKER Harry S. Witzke ADDRESS 1531 W. Lombard St.12-1928 C. HARRISON JONES, M. D.  
Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 31551

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31551

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1135 Ashburton St. 16-68 Ward)

Registered No. ....

## 2-FULL NAME

(a) Residence No. 1135 Ashburton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-STATUS

Married

(Write the word)

5a-If married, widowed, or divorced

HUSBAND of (or) WIFE of

Margaret Wright

6-DATE OF BIRTH (month, day and year)

Nov. 26-1859

7-AGE

68 yrs. 3 mos. 14 ds.

If LESS than 1 day

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Dry Goods

(c) Name of employer

9-BIRTHPLACE (city or town; State or Country)

Ind.

10-NAME OF FATHER

Clinton Wright

11-BIRTHPLACE OF FATHER (city or town; State or Country)

Ind.

12-MAIDEN NAME OF MOTHER

Sarah Clayton

13-BIRTHPLACE OF MOTHER (city or town; State or Country)

Ind.

14-

(Informant)

(Address)

Mrs. Margaret Wright  
1135 Ashburton St.

15-

Filed

G. HAMMOND JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

3/11/28

17- I HEREBY CERTIFY, That I attended deceased from

Mar 5, 1928 to Mar 11, 1928

that I last saw him alive on Mar 11, 1928

and that death occurred, on the date stated above, at 9:50 p.m.

The CAUSE OF DEATH\* was as follows:

myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Ch. Diabetes mellitus

(Duration) yrs. mos. ds.

18-Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E. E. Jacobson, M. D.

3/12, 1928 (Address) 1355 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR DATE OF BURIAL

Christybury Md. Nov. 13, 1928

20-UNDER TAKER

ADDRESS

George Schwab, 401 Buck Ave.

E 31552

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31552

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Womens Hospital* 8-40  
 CITY OF BALTIMORE: (No. ST. WARD)  
 2-FULL NAME *Mrs. Margaret Elizabeth Scroggs*  
 (a) RESIDENCE No. *3151* *Remond* ST. WARD  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred *23* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mrs. Harry B. Scroggs*

6 DATE OF BIRTH (month, day, and year) *Mar. 23, 1904*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*23* *11* *16*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltd. Md.*  
 (State or country)

10 NAME OF FATHER *Mr. Christopher J. Scroggs*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore*  
 (State or country) *Baltd.*

12 MAIDEN NAME OF MOTHER *Barton, Bertha*

13 BIRTHPLACE OF MOTHER (city or town) *Baltd.*  
 (State or country)

14 Informant *Mr. C. J. Goldbeck*  
 (Address) *2410 E. Monument St.*

12 1928 *C. HAMPTON JONES, H. U.*  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 9* 19*28*

17 I HEREBY CERTIFY, That I attended deceased from *Feb. 27*, 19*28*, to *Mar. 9*, 19*28*, that I last saw *her* alive on *Mar. 9*, 19*28*,

and that death occurred, on the date stated above, at *3:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cardiac dilatation with myocardial failure.*

(duration) yrs. mos. ds.

CONTRIBUTORY *Toxic vomiting of pregnancy*  
 (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *?*

Did an operation precede death? *Yes* Date of *Feb. 27, 1928*

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *B. H. Brock*, M. D.

, 19 (Address) *Womens Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
 MOVAL *Oak Lawn Cem*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Mrs. E. Miller & Son* *2334 Jefferson St.*

E 31553

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31553

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *521 N. Rose* ST., *7-10* WARD)2-FULL NAME *Susanna B. Rosenberger*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. *521 N. Rose* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
or) WIFE of*Lawrence Rosenberger*6 DATE OF BIRTH (month, day, and year) *Dec. 4, 1854*7 AGE Years *73* Months *3* Days *7* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.*  
(State or country) *Md.*10 NAME OF FATHER *Michael Weisel*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)14 Informant *Lewis Rosenberger*  
(Address) *2409 Eager Place*15 Filed *12-19-28* 19 *HAMPTON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-11-28*17 I HEREBY CERTIFY, That I attended deceased from *3-1* to *3-11* 19*28* that I last saw him live on *3-10* 19*28*and that death occurred on the date stated above, at *4 A. M.*

The CAUSE OF DEATH\* was as follows:

*Coronary Arteriosclerosis  
& Heart Failure*CONTRIBUTORY (Secondary) *Arteriosclerosis*  
(duration) yrs. *3* mos. ds.18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Findings*  
(Signed) *J. H. Jones, M. D.*Address *807 N. Main St.*

\*State the Disease Causing Death, or in death from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

10 UNDERTAKER *Holy Redeemer Sem.* *Mar 14 1928**Mass. C. Walker & Son* *2334 Jefferson St.*



E 31554

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31554

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Sinai Hospital 5-8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. WARD)

2-FULL NAME

John Magenta

(a) RESIDENCE NO.

432 J. Cosgrove

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Bachel.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 30, 1923

7 AGE

4.

Years

Months

Days

18

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Chas Magenta

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Carmela Carbone

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Chas Magenta 432 J. Cosgrove St.

15

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/11

19 28

17

I HEREBY CERTIFY, That I attended deceased from

4/6

19 28, to

8/11

19 28

that I last saw him alive on

3/11

19 28

and that death occurred, on the date stated above, at

1101 m.

The CAUSE OF DEATH\* was as follows:

T.B. meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

432 J. Cosgrove

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

T.B. C. &amp; spinal fluid

(Signed)

B. Cohen

M. D.

(Address)

Sinai Hospital

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Cent.

DATE OF BURIAL

3/13 1928

20 UNDERTAKER

ADDRESS

Leo J. Ruth, 1735 Harbor Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31555

E 31555

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1109 St. 16-23 Ward)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Male

Col

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

3-11-1928

## 7 AGE

Years

Months

Days

IF LESS than 1 day 5 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

12 1928

G. HAMPSON JONES, M. D.

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 11 1928

## 17

I HEREBY CERTIFY that I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thirteen and from the evidence obtained by said

inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Asphyxia

(duration) yrs. mos. 5 hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 5 hrs.

(Signed) M. D.

(Address) 143 N. Bury

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt Auburn Cem

3/12 1928

## 20 UNDERTAKER

Hemmett Carter

Address 96

62 ave

Very important. See instructions on back of certificate.

E 31556

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31556

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital* ST. *8-17* WARD)2-FULL NAME *Henry Grocup*(a) RESIDENCE No. *717 N Caroline* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE *55* Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *Valentine Grocup*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto*12 MAIDEN NAME OF MOTHER *Margaret*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto*

14

Informant (Address)

*Hoof Records*

15

C. HAMPSON JONES, H. D. Registrar

12 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-7-1928*17 I HEREBY CERTIFY, That I attended deceased from *12-20*, 19*27*, to *3-7-*, 19*28*, that I last saw him live on *3-7-*, 19*28*, and that death occurred, on the date stated above, at *2:00* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma Base of Tongue*

CONTRIBUTORY (Secondary)

*Carcinoma* (duration) yrs. mos. ds. *Criminal Bronchopneumonia* (duration) yrs. mos. ds. *2*18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Signs* (Signed) *W. H. Jones* M. D.19 (Address) *Balti City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-NOVAL

DATE OF BURIAL

*Gold Rose Hills**3/14/28*

UNDERTAKER

ADDRESS

*W. H. Jones**131 Rigney*

21429  
E 31557

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113 E 31557

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 1-3

WARD)

## 2-FULL NAME

Helen STANIEWSKA

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No.

2322 Fleet

ST.

WARD

City

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

12-23-27

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Md - Balt. Md.

## 10 NAME OF FATHER

John Staniewski

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

Jessie Zukorski

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt. Md.

## 14

Informant (Address)

St. - 76 ends

## 15

F. 121928

C. HANSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 12 1928

## 17

I HEREBY CERTIFY, That I attended deceased from Feb-13, 1928, to March 12, 1928.

that I last saw her alive on March 12, 1928.

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Bilateral otitis media (in a premature twin)

(duration) yrs. mos. 10 ds.

## CONTRIBUTORY (Secondary)

Gastro intestinal indigestion (duration) yrs. mos. 7 ds.

## 18 Where was disease contracted if not at place of death?

in Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. F. Bennett, M. D.

Mar. 12 1928 (Address) Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Holy Rosary March 14 1928

## 20 UNDERTAKER

## ADDRESS

John M. Weber 4012 Chester



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31558

## CERTIFICATE OF DEATH.

E 31558

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1148* *Drutal Parlor of J. Hill* *447-24* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *538 H. Hoffman* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)*Female**Col**Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1902*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.*26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....*House Work*(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country)

*md*

10 NAME OF FATHER

*Alford Rogers*

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

*md*

12 MAIDEN NAME OF MOTHER

*not known*

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

*md*

14

Informant  
(Address)*M E Balken**538 W Hoffman St*

15 Filed

*2 1928*

16

*G HAMPTON JONES, M. D.*

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10 1928*

17

I HEREBY CERTIFY That I took charge of the

remains described above, held an *Inquest*  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest*  
(Inquest, au-topsy or inquiry.) And that said deceased came to *her* death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Acc Poisoning*  
*Novocainus. Drutal Extract*

## CONTRIBUTORY

(Secondary)

*Shock*  
*May 9 1928*  
*1436 Broadway*(Signed) *G E Jones* M. D.(Address) *1436 Broadway*\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Menns and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial

*MOYAL*  
*M. Culture Cemetery* *3/4 1928*

20 UNDERTAKER

*Samuel Easton* ADDRESS *916 Pa. Ave*

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31559

E 31559

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital 15-21* WARD)2. FULL NAME *Madeline Lockman*(a) RESIDENCE NO. *1811 Kavanagh*

(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs.

ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**Negro**widowed*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

*James Lockman*

6 DATE OF BIRTH (month, day, and year)

*1890*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*38*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Domestic 0/0*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at home.*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto Md.*

10 NAME OF FATHER

*William Carter*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto Md.*

12 MAIDEN NAME OF MOTHER

*Rebecca Jones*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

14

Informant (Address)

*William Carter 1811 Kavanagh St.*

15

Filed

*12 1928**HARRISON JONES, R. I.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/10/ 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*1/13/18*, 19 *28*, to *3/10/28*, 19 *28*,that I last saw her alive on *3/10/28*, 19 *28*,and that death occurred, on the date stated above, at *12:30 p. m.*

The CAUSE OF DEATH\* was as follows:

*cardio-vascular renal Disease*

(duration) yrs. mos. ds.

CONTRIBUTORY *acute cardiac dilatation*

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *H. Lawrence Fahmy*, M. D., 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Auburn cemetery**3/13 1928*

20 UNDERTAKER

*Thomas E. Nelson*

ADDRESS

*1303 Preston St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31560

## CERTIFICATE OF DEATH.

74001  
E 31560

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7-10 Ward)2-FULL NAME Catherine Hoerner(a) RESIDENCE NO. 613 N. Luzerne Ave St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) widow5a If married, widowed, or divorced  
HUSBAND of Late Frank X Hoerner  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov 27/18667 AGE Years 61 Months 3 Days 12 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) At home.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)10 NAME OF FATHER Michael Voltz11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.  
(State or country)12 MAIDEN NAME OF MOTHER Catherine13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.  
(State or country)14 Informant Geo. A. Hoerner  
(Address) 613 N. Luzerne Ave15 21028 19 HARTSON JONES, H. D.  
Registrar

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to her death  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably ApoplexyHypertension for some time)

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)(Signed) [Signature] M. D.  
(Coroner)3/12/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Redeemer Cemetery Mary 13 1928

20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Harford ave.

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31561

## CERTIFICATE OF DEATH.

90 E 31561

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1915 Rosedale 15-67 Ward)2-FULL NAME Margaret M. Weidner(a) RESIDENCE NO. 1915 Rosedale St. 15-67 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 Color or Race White 5 ~~Single~~ Married, Widowed, or Divorced (write the word) Widowed6a If married, widowed, or divorced HUSBAND of (or) WIFE of Late William F. Weidner6 DATE OF BIRTH (month, day, and year) Feb 29, 19167 AGE Years 5 Months 2 Days 11 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) None(c) Name of employer None

## 9 BIRTHPLACE (city or town)

(State or country) Balt10 NAME OF FATHER William Henry11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Margaret Duff13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)14 Informant Margaret Conway  
(Address) 1915 Rosedale St17 1928 HAMPSON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 192817 I HEREBY CERTIFY, That I attended deceased from Oct 1927, to Mar 10, 1928, that I last saw him alive on Mar 10, 1928, and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH\* was as follows:

Myocarditis(duration) .....yrs. 6 mos. ....ds.

## CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of Feb 10 1928Was there an autopsy? noWhat test confirmed diagnosis? Autopsy(Signed) A. C. Brown, M. D.(Address) 4209 Schuyler Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Bury March 13 1928

## 20 UNDERTAKER

ADDRESS

George F. Ruth 1735 Harbor

very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31562

## CERTIFICATE OF DEATH.

90 E 31562

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Colonial Hospital-24* St., *24* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *1308 W. Carroll* St. *24* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color *colored*5 Single, Married, Widowed,  
or Divorced, (write the word) *unknown**male*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of *unknown*6 DATE OF BIRTH (month, day, and year) *18.67*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.*61*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work *Laborer*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Hot Springs*(State or country) *A. R. K.*10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *unknown*12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *unknown*

14

Informant  
(Address) *Charles Nelson, 1100 N. 11th St.*15 *2* 192816 *HARRISON JONES, M. D.*

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 9 1928*

17

I HEREBY CERTIFY that I have examined the

remains described above, held an *Inquest*  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest*and that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH was as follows:

*Tubercle of Lungs*18 CONTRIBUTORY  
(Cause)*12/28* (duration) *6* mos. *3* ds.*143 N. 11th St.* (Address) *143 N. 11th St.**143 N. 11th St.* (Address) *143 N. 11th St.*\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL*mt Auburn cemetery* Date of Burial *3/13 1928*

20 UNDERTAKER

*Thomas E Nelson* ADDRESS *1305 Princeton St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31563

## CERTIFICATE OF DEATH

E 31563

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Sydenham Hospital* St. *16* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *721 Edgewood* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*May 20, 1920*

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

*7**9**21*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

*Baltimore*

(State or country)

*Maryland*

10 NAME OF FATHER

*John Allen Steffy*

11 BIRTHPLACE OF FATHER (City or town)

*Westminster*

(State or country)

*Maryland*12 MAIDEN NAME OF MOTHER *Margaret McConnell*

13 BIRTHPLACE OF MOTHER (city or town)

*Baltimore*

(State or country)

*Maryland*

14

Informant (Address)

*John A. Steffy**721 Edgewood St.*15 *May 13 1928* *BAUTMAN JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*March 12, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 10, 1928, to March 12, 1928*that I last saw him alive on *March 11, 1928*and that death occurred, on the date stated above, at *3:15 a. m.*

The CAUSE OF DEATH\* was as follows:

*Streptococcus Meningitis*(duration) \_\_\_\_ yrs. \_\_\_\_ mos. *4* ds.CONTRIBUTORY *Terminal Pneumonia*

(Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. *1* ds.

18 Where was disease contracted

if not at place of death? *At home*Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *Bacteriological*(Signed) *J. A. Steffy*, M. D.*3-12-1928* (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*St. Anne's Cathedral*

19

20 UNDERTAKER

ADDRESS

*Geo W Little*

of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 31564

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2923 N. Linnale St. 16-67 WARD)

## 2-FULL NAME

John Christian Meyers

(a) RESIDENCE NO. 2923 N. Linnale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a Married, widowed, or divorced HUSBAND of (or) WIFE of Mary Meyers

6 DATE OF BIRTH (month, day, and year) May 27-1854

7 AGE 73 Years 3 Months 14 Days 5 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired buyer of

(b) General nature of industry, business, or establishment in which employed (or employer) Packing house

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Ernest W. Meyers

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Anna Linslein

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs. Mary Tiers (Address) 2923 N. Linnale St.

15 HAMILTON JONES, M. D.

R 13 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17-1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 6-1928, to May 17, 1928,

that I last saw him live on May 11, 1928,

and that death occurred, on the date stated above, at 7:10 A.M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

(Address) 1837 Grand Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Carmel Cem

March 14 1928

20 UNDERTAKER

ADDRESS

Ger. H. Little

2750 Edmondson

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31565

## CERTIFICATE OF DEATH.

90 E 31565

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 431 Hutchins St. 27-48 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 431 Hutchins St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Feb - 19167 AGE Years 12 Months 1 Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) Baltimore City Md.10 NAME OF FATHER John W. Morris11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) Md.12 M maiden NAME OF MOTHER Ann Boston13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) Md.14 Informant John W. Morris (Address) 431 Hutchins15 Filed \_\_\_\_\_ 19 28 C. HANDESON JONES, R. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10-192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Tabular Disease of Heart (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_

(Signed) John W. Morris M. D.(Address) 2622 Roland

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if \_\_\_\_\_ at place of death \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 3/13/2820 UNDERTAKER Wm. Auburn ADDRESS 916

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

AR 13 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31566

E 31566

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1301 Scheele Ave. 70-38* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *1301 Scheele Ave.* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth *Life* mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Elizabeth Ernst*6 DATE OF BIRTH (month, day, and year) *March 21 1871*7 AGE Years *56* Months *11* Days *16* IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Business*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Agent*  
(c) Name of employer *Machinist Union*

## 9 BIRTHPLACE (city or town)

(State or country) *New York*

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Germany*

## 14

Informant (Address) *Elizabeth Ernst*  
*1301 Scheele Ave.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 7* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *April 20*, 19 *27*, to *March 7*, 19 *28*, that I last saw him alive on *March 6*, 19 *28*, and that death occurred, on the date stated above, at *2 15* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *E. J. Wallace*, M. D.  
, 19 (Address) *Wilmington*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR

Date of Burial

*St. Carmel's Church March 10 1928*  
UNDER TAKER *William H. Sord Rafter*  
ADDRESS

13 Filed

G. HAMPTON JONES, Registrar  
*RPH*

very important. See instructions on back of certificates. Exact statement of OCCUPATION in plain terms, so that it may be properly classified.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31567  
1-PLACE OF DEATHCITY OF BALTIMORE: (No. *610 Myeth*)2-FULL NAME *Thomas Jamison*(a) RESIDENCE NO. *610 Myeth*

(Usual place of abode)

Length of residence in city or town where death occurred

*74* yrs. *2* mos. *2* ds.

ST.,

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Elizabeth Jamison*

6 DATE OF BIRTH (month, day, and year)

*Jan 10 1854*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*74**2**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*United R.R.*9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md.*

10 NAME OF FATHER

*John Jamison*

11 BIRTHPLACE OF FATHER (city or town)

*Baltimore Md.*

12 MAIDEN NAME OF MOTHER

*Mary Ann Green*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore Md.*

14

Informant

(Address)

*Elizabeth Jamison*  
*610 Myeth St*

Filed

13 1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-12 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*November 1, 1927, to March 12, 1928.*that I last saw him alive on *March 10, 1928.*and that death occurred, on the date stated above, at *1:30 A. M.*

The CAUSE OF DEATH\* was as follows:

*arterio sclerosis*

(duration)

yrs.

mon.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

3/12, 1928

(Address)

*301 E. Enoch St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Baltimore Cemetery**3-14 1928*

20 UNDERTAKER

ADDRESS

*Bernard C. Harle, 1000 S. Paca St.*

E 31568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 31568

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital 26-37* St. *101* Ward *1001*)

2-FULL NAME

(A) RESIDENCE NO.

*Edgmon Md. St.*

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

25 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male white Single*  
6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1889*

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

*39*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Russia*

10 NAME OF FATHER

*John Felucik*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Russia*

14

Informant (Address)

*John Narutovics Edgmon*

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 11 1928*

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

THE CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

CONTRIBUTORY (Secondary)

*Mar 11/28* (duration) yrs. mos. 2 ds. *Chas. H. Shaw* (Signed) *Geo. Chas. Shaw* (Coroner) M. D.

*143 N. Broadway* (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Buried heart of Mary Warak 4/28*

20 UNDERTAKER

ADDRESS

*J. W. Gzowski 1930 Eastern Ave*

Very Important. See instructions on back of certificate.

MAR 13 1928

E 31569

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31569  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 25-72 Ward)2-FULL NAME John J. O'Keefe(a) RESIDENCE NO. Frederick Road in Nunnery Lane Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 66 Years 8 Months 1 Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Mfg.  
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER Daniel O'Keefe

11 BIRTHPLACE OF FATHER (city or town).....  
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Connell

13 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) Ireland

14 Informant Mr. Wm. J. O'Keefe  
(Address) Frederick Rd. nr.

15 Filed.....  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1928 192

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to this death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cardio. Nephritis (Cause)  
uraemia  
(duration) 7 yrs. 7 mos. 7 ds.

CONTRIBUTORY Struck by auto  
(See reverse side) Concussion of brain  
(duration) 13 hrs. 13 mos. 13 ds.  
M.D. (Signed) Thos. B. Burton M. D.  
(Coroner)

12-19-28 (Address) Cedar and Curtis Aves.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Mar. 11, 1928

20 UNDERTAKER Wm. J. O'Keefe ADDRESS 1003 West Baltimore St

very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31570

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 14-20 Ward)2-FULL NAME B. Ridgaway Henrix(a) RESIDENCE NO. 2015 Linden Avenue St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX \_\_\_\_\_ 4 Color or Race \_\_\_\_\_ 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year)  
August 4, 18687 AGE Years \_\_\_\_\_ Months 7 Days 7 IF LESS than 1 day.....hrs. or.....min.  
59 6 17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk & Bookkeeper(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore(State or country) Maryland10 NAME OF FATHER Edward Henrix11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Anne Groscup13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland14 Informant Miss Anne J. Henrix  
(Address) 2015 Linden Ave.

15 Filed \_\_\_\_\_, 19 \_\_\_\_\_ Registrar

REGISTERED 31570

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1928 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-inquiry and that said deceased came to his death  
(topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured skull

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Subdural hemorrhage  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) Eugene J. Zeller M. D.  
(Coroner)3/12/28 Address 2739 Eastern Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Greenmount CemeteryMar. 14 1928

20 UNDERTAKER

ADDRESS 1003W. Baltimore St

Very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31571

## CERTIFICATE OF DEATH.

E 31571

1-PLACE OF DEATH *1724 Darley Ave*  
 CITY OF BALTIMORE: (No. *1724 Darley Ave* ST. *8* WARD) REGISTERED NO. \_\_\_\_\_  
 2-FULL NAME *Isabella Virginia Sunstrom* (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 (a) RESIDENCE NO. *1724 Darley Ave* ST. *8* WARD  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *79* yrs. *9* mos. *26* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Calvin Sunstrom*

6 DATE OF BIRTH (month, day, and year) *May 14<sup>th</sup> 1848*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*79 9 26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*City*

## 10 NAME OF FATHER

*Robert Wilson*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

## 12 MAIDEN NAME OF MOTHER

*Thompson*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

14

Informant *Mrs. Frank E. Clark*  
 (Address) *1724 Darley Ave.*

15

Filed

MAR 13 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 10<sup>th</sup> 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Jan 19*, 1928, to *March 10*, 1928, that I last saw her alive on *Mar. 10*, 1928, and that death occurred, on the date stated above, at *8:10 a. m.*

The CAUSE OF DEATH\* was as follows:  
*Carcinoma of Stomach*

(duration) *about one* yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *at place of death*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Autopsy*

(Signed) *W. D. Macdonald*, M. D.

*Mar 12*, 1928 (Address) *1540 N. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Louisa Park Cemetery*

UNDERTAKER *E. J. Fanning, Inc. - 1938 E. Lippitt*

## DATE OF BURIAL

*3/13 1928*

ADDRESS

E 31572

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 31572

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *218* *Hullton Ave* St. *19-26* Ward)2-FULL NAME *Mrs. Margaret A. Bargar*(a) RESIDENCE NO. *218* *Hullton Ave* St. *19-26* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of *Joe A. Bargar* (or) WIFE of *Widowed*6 DATE OF BIRTH (month, day, and year) *October 23rd 1846*7 AGE *82* Years *81* Months *7* Days *18* IF LESS than 1 day—hrs. or—min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Living at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Ephraim Ferguson*11 BIRTHPLACE OF FATHER (City or town) *Savage* (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Ferguson*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore City* (State or country) *Maryland*14 Informant *Dr. A. S. Parkhurst* (Address) *1410 Park Ave*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 10th 1928*17 I HEREBY CERTIFY, That I attended deceased from *Oct*, 19*23*, to *March*, 19*28*, that I last saw her alive on *March 10*, 19*28*, and that death occurred, on the date stated above, at *10:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis, Arteriosclerosis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Alice S. Parkhurst, M. D.*. 19 (Address) *1410 Park Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Lorraine Park Cemetery**Mar 13 1928*

20 UNDERTAKER

ADDRESS

*John F. Denny**715 Light*

MAR 13 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31573

## CERTIFICATE OF DEATH.

151<sup>st</sup> E 31573

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mersey 1000 St. 10-15 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1007 Breunlewood St. 10-15 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteMarried5a If married, widowed, or divorced, HUSBAND of Belle V. Stalduff WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 18 1862

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

60

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Lab.

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14

Informant (Address)

659 E. Eager St.

G. HAMMON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, au-topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute & severe alcoholism

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

W. J. H. H. H.

(Coroner)

1928 (Address)1301 E Eager St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

In the city place of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery Date of Burial Mar. 14 1928

20 UNDERTAKER

ADDRESS

Henry Stoeck 1301 E Eager St

very important. See instructions on back of certificate.

MAR 13 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31574

## CERTIFICATE OF DEATH.

E 31574

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced, (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

3-10, 1928, to 3-12, 1928.

that I last saw him alive on 3-12-28, 19

and that death occurred, on the date stated above, at 3:55 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herman A. V. M. D.

, 19 (Address) St Joseph Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-BURIAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31575

## CERTIFICATE OF DEATH.

E 31575

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1127 Argyle Ave ST. 17-24 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1127 Argyle Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 19, 1884

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

1

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore md

10 NAME OF FATHER

Joseph Poulson

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md

12 MAIDEN NAME OF MOTHER

Laura J. Schley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore md

14

Informant (Address)

Laura Brown 1127 Argyle Ave

15

Filed

13 1928

S. H. HUGHES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1928

17

I HEREBY CERTIFY, (That I attended deceased from March 6, 1928, to March 9, 1928,

that I last saw him alive on March 9, 1928,

and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Churcal

(Signed)

J. B. Hughes, M. D.

(Address) 1413 S. Hill Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Auburn Cemetery

Mar. 13, 1928

20 UNDERTAKER

ADDRESS 322

Mrs. Kate R. Williams

R. Schrock St.

Lahn.

E 31576

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31576

1-PLACE OF DEATH

Sinai Hosp.

CITY OF BALTIMORE: (No.

ST. 6-9 WARD)

2-FULL NAME

Stanley Lahn

(a) RESIDENCE NO.

1539 E Fayette

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

1 yrs.

11 mos.

ds.

Now long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white

Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 16 1926

7 AGE

Years

Months

Days 26

If LESS than 1 day, hrs. or min.

1

11

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

Baltimore Md

10 NAME OF FATHER

Charles Lahn

11 BIRTHPLACE OF FATHER (city or town, State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Ruth Rochlin

13 BIRTHPLACE OF MOTHER (city or town, State or country)

Russia

14

Informant  
(Address)Charles Lahn  
1539 E Fayette

15

Filed

3/13 1928  
HARRISON JONES, JR.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/1/28

17

I HEREBY CERTIFY, That I attended deceased from

3/1/28, 1928, to 3/1/28, 1928.

that I last saw him alive on

3/1/28, 1928.

and that death occurred, on the date stated above, at

1300 P. M.

The CAUSE OF DEATH\* was as follows:

Hemorrhagic Encephalitis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? 1539 E Fayette St

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Haskin, M. D.

3/13 1928 (Address)

Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Rehman Burial

DATE OF BURIAL

3/13 1928

20 UNDERTAKER

Jack Lewis 1439 E Fayette St

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 31577

## CERTIFICATE OF DEATH.

90 E 31577

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. North* ST. *10-71* WARD)2-FULL NAME *John J. Gersbach*(a) RESIDENCE NO. *517 N. Collins Ave.* ST. *10-71* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *4 yrs.* mos. *0* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed or Divorced, (write the word)

*Married*5a If married, widowed, or divorced HUSBAND of *Jane A. Gersbach* WIFE of *Jane A. Gersbach*6 DATE OF BIRTH (month, day, and year) *Jan 19 - 1888*

7 AGE

Years

Months

Days

If LESS than 1 day *70* yrs. or *1* min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired Plumber*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Inspector Health Dep*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto* (State or country)10 NAME OF FATHER *John J. Gersbach*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Catherine Gersbach*13 BIRTHPLACE OF MOTHER (city or town) *Ireland* (State or country)

14

Informant (Address) *Sam. J. Gersbach*

15

Filed

AR 13 1928

HARVEY JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

6 DATE OF DEATH (month, day, and year) *3-10-28* 19

17

I HEREBY CERTIFY, That I attended deceased from *3-10-28*, 19 to *3-10-28*, 19that I last saw him alive on *3-10-28*, 19and that death occurred, on the date stated above, at *9:10 pm.*

CAUSE OF DEATH\* was as follows:

*Myocardial Failure*(duration) yrs. mos. *3 mos.*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *Clinical*(Signed) *Paul M. Hall*

M. D.

19 (Address) *Franklin Sq. North*

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

*New Cathedral**3-14 1928*

20 UNDERTAKER

ADDRESS

*H. B. Cunningham 1136 Calver St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31578

## CERTIFICATE OF DEATH.

90 ✓ E 31578

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 906 N. Madeira St. 7-12 Ward)

2-FULL NAME Catherine Vancura

(a) RESIDENCE NO. 906 N. Madeira St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wenceslaus Vancura

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 88 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Austria

10 NAME OF FATHER Jos. Polavka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14

Informant Antonio Vancura (Address) 906 N. Madeira St.

FILE 1926 C. HAMPTON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 Mar 12/8

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry find that said deceased came to her death (Inquest, au-

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY Senility (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Butler M. D. (Coroner)

3/13/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31579

## CERTIFICATE OF DEATH.

E 31579

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 S. Riverview ST., 16-31 WARD)2-FULL NAME Edward V. Bynion(a) RESIDENCE No. 1503 S. Riverview ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7-19277 AGE Years Months Days If LESS than 1 day, hrs or min. 8 5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Engene V Bynion11 BIRTHPLACE OF FATHER (city or town) Charm City, Md (State or country)12 MAIDEN NAME OF MOTHER Emma McKen13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)14 Informant Mrs Emily Bynion (Address) 1503 Riverview Ave

15 R 13 1928 C. HAMMON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 19 28

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1928, to March 12, 1928, that I last saw him alive on March 11, 1928, and that death occurred, on the date stated above, at 7:20 a m. The CAUSE OF DEATH\* was as follows:Whooping Cough(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Observation(Signed) Harace B. Tellow, M. D.3/12/28 (Address) 315 S. Highland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mt. Carmel Cemetery

20 UNDERTAKER

George W. Zuhler

DATE OF BURIAL

3/14 1928

ADDRESS

1737 E. Egan

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31580

## CERTIFICATE OF DEATH.

REGISTERED NO.

129 E 31580

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 914 N. Fulton Ave 16-22 Ward)2-FULL NAME Eleanora Stanislaus Keene(a) RESIDENCE NO. 914 N. Fulton Ave St. 16 Ward 22

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married6a If married, widowed, or divorced  
HUSBAND or  
(or) WIFE of Samuel A. Keene6 DATE OF BIRTH (month, day, and year) Jan-16-18447 AGE Years 84 Months 1 Days 24 IF LESS than 1 day...hrs. or...min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) Dorchester Co.,  
(State or country) Maryland10 NAME OF FATHER John E. Applegarth11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Dorchester Co., Md.12 MAIDEN NAME OF MOTHER Anna Tubman13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Dorchester Co., Md.14 Informant Cecelia Keene  
(Address) 914 N. Fulton Ave15 Filed 15 1928 G. STANTON JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 192817 I HEREBY CERTIFY, That I attended deceased from February 15, 1928, to March 12, 1928, that I last saw him alive on March 11, 1928, and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral HemorrhageCONTRIBUTORY Chronic Interstitial Nephritis  
(Secondary)(duration) unknown yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical Signs & Symptoms(Signed) Chester Ireland, M. D.3-12-1928 (Address) 2532 Edmondson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

Date of Burial

3-14 1928

20 UNDERTAKER

Geo. A. Farley

ADDRESS

1600 N. Fayette St.

## HEALTH DEPARTMENT-CITY OF BALTIMORE

E 31581

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *118 S. Robinson* St. *173* Ward)2-FULL NAME *Winnie Reylor*(a) RESIDENCE NO. *118 S. Robinson* St. *1* Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widow*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*the late Carl Reylor*

6 DATE OF BIRTH (month, day, and year)

*Mar. 19 - 1858*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hra.  
or.....min..*71 11 21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Retired*

9 BIRTHPLACE (city or town)

(State or country)

*Germany*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant  
(Address)*Henry Busch (Widow)  
118 S. Robinson St.*

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 *28**Mar. 10<sup>th</sup>*

17

I HEREBY CERTIFY. That I attended deceased from

*Mar. 7-78* to *Mar. 10-78*that I last saw *her* alive on *Mar. 10-78*, 19and that death occurred, on the date stated above, at *10<sup>15</sup> P.* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

da.

(duration)

yrs.

mos.

da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*D. D. Surman*

M. D.

(Address)

*Mar. 13-78 2913 E. Pratt*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Linden Park  
Oak Lawn Cemetery**Mar. 14*19 *28*

20 UNDERTAKER

ADDRESS

*Lilly & Zeiler Inc.**403 S. Holler*

Very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31582

## CERTIFICATE OF DEATH

REGISTERED NO.

E 31582

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 266 S. Duncan St. 173 Ward)2-FULL NAME Alice L. Bew.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 266 S. Duncan St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs.  mos.  da. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Bew6 DATE OF BIRTH (month, day, and year) Dec. 18897 AGE 39 Years Months Days IF LESS than 1 day.....hrs. or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) King Queen Co. Va. (State or country)10 NAME OF FATHER John J. Williams

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Williams13 BIRTHPLACE OF MOTHER (city or town) (State or country) King Queen Co. Va.14 Informant Gertrude L. Bullock (Address) 2701 E. Jefferson St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 19 2817 HEREBY CERTIFY, That I attended deceased from 3/4/28, 1928, to 3/10, 1928, that I last saw her alive on 3/9, 1928.and that death occurred, on the date stated above, at 10:15 a.m.  
The CAUSE OF DEATH\* was as follows:Acute Diffuse NephritisCONTRIBUTORY Cerebral intoxication (Secondary)18 Where was disease contracted at home  
If not at place of death?Did an operation precede death? no Date of -  
Was there an autopsy? noWhat test confirmed diagnosis? urinalysis  
(Signed) J. H. Farrell M. D. (Address) 653-5-3rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial Mar. 19 1928  
20 UNDERTAKER Lilly & Feiler Inc. ADDRESS 403 S. Wolfe St.

Very Important. See instructions on back of certificates.

MAR 1

G. H. J. ON JUNE 11 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31583

## CERTIFICATE OF DEATH.

31 E 31583

## 1-PLACE OF DEATH

City of BALTIMORE: (No. N. W. Cor Eden & Lexington Sts Ward)2-FULL NAME Clara Banks(a) RESIDENCE NO. 302 N Caroline St

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 Color or Race

col

5 Single, Married, Widowed,  
or Divorced, (write the word)

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

John Banks

6 DATE OF BIRTH (month, day, and year)

Mar 22/88

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

39

11

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Cook

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Restaurant

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

St. Mary's Co Md.

10 NAME OF FATHER

Wm. Medley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Ellen Butler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant Columbus Medley  
(Address) 667 Moore St

MAR 13 1928

P.

Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

5-9

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14/28

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, au-topsy or inquiry.) And that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Shock- hemorrhage nose & mouth  
Probably Tuberculosis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) [Signature] M. D.

(Coroner)

3/13/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL, CREMATION OR Date of Burial

Burial

Burial

Burial

Burial

Burial

Burial

Burial

Burial

Burial

Burial

Burial

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31584

## CERTIFICATE OF DEATH.

75-001 E 31584  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 4-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Allen(a) RESIDENCE No. 1908 Mc Culloch ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds.How long in U. S., if of foreign birth? 7 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male colored single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

cupper plumber

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

William Allen

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Records

15

Filed

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 9, 1928, to Mar. 11, 1928that I last saw him on Mar. 11, 1928and that death occurred, on the date stated above, at 8:20 A. M.

The CAUSE OF DEATH\* was as follows:

Demiplegia - right  
arteriosclerosis  
hypertension(duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. J. Jones M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

W. J. Jones3/12/28

UNDERTAKER

ADDRESS

Registrar





31586

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31586

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Sydenham Hospital

REGISTERED NO.

City of BALTIMORE: (No.

St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Roxie Lee Blake

(a) RESIDENCE NO.

1239 E. Monument

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. da.

How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 Color or Race

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 4, 1915

7 AGE

Years

Months

Days

12

4

8

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

School

(c) Name of employer

9 BIRTHPLACE (city or town)

Va.

(State or country)

10 NAME OF FATHER

Fred Wharton

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Irene Blake

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va.

14

Informant (Address)

Sydenham Hosp. Record

15 Filed

R 13 1926

C. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 19 28

17

I HEREBY CERTIFY, That I attended deceased from

March 10, 1928, to March 12, 1928,

that I last saw him alive on March 12, 1928,

and that death occurred, on the date stated above, at 2:50 P. M.

The CAUSE OF DEATH\* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Spinal fluid exam.

(Signed)

J. S. Sackman

M. D.

, 19

(Address)

Sydenham Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oyster Creek Cemetery Mar. 14 1928

20 UNDERTAKER

Chas. N. Johnson 4607, Caroline St.

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31587

## CERTIFICATE OF DEATH

31 E 31587

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2223 Maryland Ave. Ward 12-51)

## 2-FULL NAME

(a) RESIDENCE NO. 2223 Maryland Ave. Ward 12-51

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

Female White Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191924, to Mar 11, 1928.that I last saw her alive on Mar 11, 1928.and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Pulmonary TuberculosisCONTRIBUTOR (duration) 4 1/2 yrs. mos. ds.(Secondary) Acute Pleurisy 4 days

(duration) \_\_\_\_ yrs. mos. ds.

13 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of \_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? X-ray(Signed) Carroll Lockard, M. D.(Address) 445 Presler St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Gruid Ridge ArmyMarch 1928

UNDERTAKER

ADDRESS

John C. Mitchell & Sons 1900

Very Important. See instructions on back of certificates.

E 31588

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31588

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3515 Benson St. 13-57 Ward)2-FULL NAME Catherine V. Warehime(a) RESIDENCE NO. 3515 Benson St. 13-57 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. Life mos. ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)Femalewhitesingle5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofChild

6 DATE OF BIRTH (month, day, and year)

Jan 22, 1928

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

119

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workChild(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

md.

(State or country)

10 NAME OF FATHER

Alfred Warehime

11 BIRTHPLACE OF FATHER (city or town)

md.

(State or country)

12 MAIDEN NAME OF MOTHER

Catherine Singer

13 BIRTHPLACE OF MOTHER (city or town)

md.

(State or country)

14

Informant  
(Address)Alfred Warehime  
3515 Benson St.

AR 13 1928

HAMPSON JONES, M. D.

20 UNDERTAKER

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Woodlawn CemMarch 13, 1928Chenoweth3615 Chestnut

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

March 12

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

and that said deceased came

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH was as follows:

Broch Pneumonia

(duration).....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration).....yrs. ....mos. ....ds.

(Signed) J. H. Jones M. D.

(Coroner)

3632 Roland\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place  
of death.....yrs. ....mos. ....ds. In the  
State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31589

## CERTIFICATE OF DEATH.

90 E 31589

PLACE OF DEATH

City of BALTIMORE: (No.

On a lot in the rear of  
1114 Haubert St.

St. 13-59 Ward

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

2-FULL NAME

Patrick J. Morris.

(a) RESIDENCE NO. 2564 Druid Park Drive.

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? 48 yrs.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male.

White.

Single.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

November 6, 1872

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

55

4

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Ireland.

10 NAME OF FATHER

Peter Morris.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland.

12 MAIDEN NAME OF MOTHER

Bridget McManus.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland.

14

Informant Luke Romig. (brother-in-law)  
(Address) 2564 Druid Park Drive

15 Filed 13 1928

P. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 11, 1928

192

17

I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.) and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency.  
Acute dilatation of the heart.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) John B. Binkley M. D.  
(Coroner)

3/13, 1928 (Address) 1017 E. Charles St

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Cathedral Cem.March 14 1928Margaret H. Lynd1422 Light



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31590

## CERTIFICATE OF DEATH.

73.E 31590

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hosp.* ST. *28-63* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *Mt Hope Retreat, City*

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. *0* mos. *0* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD *Resident*

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? *50* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *2*4 COLOR OR RACE *W.*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Aug 9. 1868*7 AGE *59* Years

Months

Days

If LESS than 1 day, hrs or min. *60* *7-* *-2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Sister of Charity*(b) General nature of industry, business, or establishment in which employed (or employer) *Nurses.*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *Michael Hinnelly*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Annora Lyons.*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *Sister Elizabeth*

15

Filed

19

NON JONES, R. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-11-1928*

17

I HEREBY CERTIFY, That I attended deceased from *12-10*, 19*27*, to *3-11*, 19*28*,that I last saw her alive on *3-11*, 19*28*and that death occurred, on the date stated above, at *7:20 P* m

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*

CONTRIBUTORY (Secondary)

(duration) yrs. *12* mos. *12* ds. *Transverse Myelitis*(duration) yrs. *3* mos. *ds.*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Ray & Thy Exam.*(Signed) *Francis L. Sadeghbeigi*, M. D., 19 (Address) *St. Agnes Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Mt Hope Cemetery**Mar 14/ 1928*

20 UNDERTAKER

ADDRESS

*Shewan-Morrow Co. Balto.*

E 31591

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2738 Riggs Ave ST. 16-68 WARD)

## 2-FULL NAME

Charles Krantz Roberts

(a) RESIDENCE NO. 2738 Riggs Ave

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 6 mos. 7 ds.

ST.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Sept-4-1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

53

6

7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Society to the City

(b) General nature of industry, business, or establishment in which employed (or employer)

Produce Jobbers

(c) Name of employer

Association

9 BIRTHPLACE (city or town) (State or country)

Maitinsburg West-Va.

10 NAME OF FATHER

Eli S. Roberts

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maitinsburg West-Va.

12 MAIDEN NAME OF MOTHER

Fannie Krantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maitinsburg Maryland

14 Informant (Address)

Mrs Fannie S. Roberts (mali) 2738 Riggs Ave.

15 Filed

G. E. JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 9 1928 to Mar 11 1928

that I last saw him live on Mar 11 1928

and that death occurred, on the date stated above, at 50 m

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration)

yrs.

mos

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos

ds.

18 Where was disease contracted

if not at place of death?

Place of death

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

John A. Chapman, M. D.

Address) 1219 Copland Street

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Mount Cemetery

Mar 13 1928

UNDERTAKER

ADDRESS

Edward Monahan

Balto.

E 31592

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST. 12 WARD

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

70 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 86 yrs. 6 mos. 17 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11, 1928

17

I HEREBY CERTIFY, that I attended deceased from

Nov. 17, 1927, to Mar. 11, 1928.

that I last saw him alive on March 11, 1928

and that death occurred, on the date stated above, at 7-45 P. m.

The CAUSE OF DEATH\* was as follows:

Uremic Coma due to Chronic Interstitial Nephritis. Left Hemiplegia due to Cerebral Thrombosis (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Senile Arterio-Sclerosis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. Gibson Fortin, M. D.

(Address) 422 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31593

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3821 Dalrymple Ave.

2-FULL NAME Mary Elizabeth Overend

(a) RESIDENCE No. 3821 Dalrymple Ave

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

ST. 15-65 WARD 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Collins Overend

6 DATE OF BIRTH (month, day, and year) Sept-17-1941

7 AGE Years 86 Months 5 Days 25 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Near Dover Delaware (State or country)

10 NAME OF FATHER James Henry Shuster

11 BIRTHPLACE OF FATHER (city or town) ? ? (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Elizabeth Lord

13 BIRTHPLACE OF MOTHER (city or town) Sayreville New Jersey (State or country)

14 Informant Mrs. William Ray Pitt (daughter) (Address) 3821 Dalrymple Ave.

15 Filed 13 1920 C. H. [Signature] Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1928

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to March 17, 1928, that I last saw him alive on March 17, 1928, and that death occurred, on the date stated above, at 5-15 PM.

The CAUSE OF DEATH\* was as follows:

Endocarditis, Scurvy Ulcer

CONTRIBUTORY (duration) 9 yrs. mos. ds. (Secondary) Chronic Indigestion Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Laboratory (Signed) J. A. D. [Signature] M.D.

19 (Address) Medical Arts Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery

DATE OF BURIAL

Mar-18-1928

20 UNDERTAKER

STEWART &amp; MOWEN COMPANY

ADDRESS

103 W. NORTH AVE



E 31594

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 Granby St ST. 3-5 WARD)2-FULL NAME John Levin(a) RESIDENCE NO. 1034 Granby St  
(Usual place of abode)Length of residence in city or town where death occurred 37 yrs. mos.

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 37 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

white5 Single, Married, Widowed,  
or Divorced, (write the word)Married5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE ofElaine Levin

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.84

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workHousewife(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Russia

14

Informant

(Address)

Elaine Levin1034 Granby St

15

Filed

13 1928R. H. H. ON

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/13 19 28I HEREBY CERTIFY, That I attended deceased from  
Jan 15, 19 28, to March 12, 19 28,  
that I last saw her alive on March 12, 19 28,and that death occurred, on the date stated above, at 79 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma esophagus

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)Myocarditis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

clinical

(Signed)

M. J. Baylie, M. D.

3/13/28 (Address)

210 Poplar\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Bethesda3/13 19 28

20 UNDERTAKER

ADDRESS

John Lewis 1439 E. Pratt St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31595

## CERTIFICATE OF DEATH

E 31595

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1517 St. Mulberry 19-27 St. Ward)

## 2-FULL NAME

Thomas Edward Dorsey

## (a) RESIDENCE NO.

1517 St. Mulberry

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

Col

## 5 Single, Married, Widowed, or Divorced. (Write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Apr 14 1927

## 7 AGE

Years Months Days

10 28

IF LESS than  
1 day... hrs.  
or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md

## 10 NAME OF FATHER

Marshall Thomas Dorsey

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Hannah Walker

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore Md

## 14

Informant  
(Address)Hannah Walker  
1517 St. Mulberry St

## 15 Filed

13 1928

G. 19 J. H. JONES, R. S.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 12 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 28 1928 to Mar 12 1928,

that I last saw him alive on Mar 12 1928,

and that death occurred, on the date stated above, at 7:15 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Western Star.

3-14-1928

## 20 UNDERTAKER

Joseph A. Lively

ADDRESS

409 N. Mount Street



E 31597

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7-9 ST., WARD)

## 2-FULL NAME

(a) RESIDENCE NO. Home de Grace Md.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15 Filed

R 13 1928

JAMESON JONES, N. S.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
2 - 26, 1928, to 3 - 12, 1928

that I last saw him alive on 3 - 12, 1928

and that death occurred, on the date stated above, at 2:35 P. m.

The CAUSE OF DEATH\* was as follows:

FREMATUREITY

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) ? yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. H. Cullenham, M. D.

(Address) 713, 1928

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Harmony Cem, Mar. 14, 1928  
H. S. Bailey Darlington, Md.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31598

## CERTIFICATE OF DEATH.

100-00 E 31598

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 105 W. York St.

St. 22-30 Ward)

2-FULL NAME Doloris Acree. (C)

(a) RESIDENCE NO. 105 W. York St.

(Usual place of abode)

St. Ward

Length of residence in city or town where death occurred 1 yrs. 9 mo. 28 ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female. Colored Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17, 1926.

7 AGE Years Months Days 24 IF LESS than 1 day.....hrs. or.....min.  
1 9 28

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Alonzie Acree. (C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland.

12 MAIDEN NAME OF MOTHER Mary Pritchett. (C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland.

14 Informant Mary Acree. C. (mother)

(Address) 105 W. York St.

15 1928

C. HAMPTON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1928. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Capillary Bronchitis.  
Laryngeal Celapsia.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) (duration) .....yrs. ....mos. ....ds.

(Coroner)

2/18/23 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

E 31599

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90-E 31599

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 122 W. Lee St.

2-FULL NAME Milton Carter.(C)

(a) RESIDENCE NO. West Point Va.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. / ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male.

Colored

Married.

6a If married, ~~XXXXXX~~  
HUSBAND of  
(~~XXXXXX~~)

Laura Carter(C)

6 DATE OF BIRTH (month, day, and year)

Do not know.

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

40

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Cook S/S City of  
Richmond.

9 BIRTHPLACE (city or town)

(State or country)

Virginia.

10 NAME OF FATHER

Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Do not know.

12 MAIDEN NAME OF MOTHER

Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Do not know.

14

Informant

(Address)

Mr. Hughes,

Chesapeake Stearship Co.

15

Filed

G. HAMPTON JONES, R. J.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)  
March 13, 1938.17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
inquiry (Inquest, au-  
topsy or inquiry.) and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficieny.  
Acute dilatation of the Heart.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) [Signature] M. D.  
(Coroner)

2/13' 19 28 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place  
of death.....yrs.....mos.....ds. In the  
State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVALWest Point Va March 13 1938

20 UNDERTAKER

ADDRESS

Chas. Brown & Son 108 W. Montgo

E 31600

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31600

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY ST. 6-11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Viles(a) RESIDENCE No. 2816 E. Baltimore ST., 6-11 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of or WIFE of August C. Viles6 DATE OF BIRTH (month, day, and year) ?7 AGE Years 49 Months ? Days ? If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia10 NAME OF FATHER James D. Viles11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia12 MAIDEN NAME OF MOTHER Kate M. Viles13 BIRTHPLACE OF MOTHER (city or town) (State or country) West VirginiaInformant (Address) Records3-1928-225-225 REGISTRAR C. HAMPTON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1928, to Mar. 13, 1928. that I last saw her live on Mar. 12, 1928, and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis(duration) yrs. 4 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Culture & Sub.(Signed) C. J. Sullivan, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Interment at St. Matthews DATE OF BURIAL Mar. 15/2820 UNDERTAKER Frank V. Phipps ADDRESS 1319Occasional Health.

E 31601

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31601

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *Johns Hopkins Hospital* ST. *7-9* WARD)2-FULL NAME *Baluy Stiffler*(a) RESIDENCE No. *Freeland, Md.* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*

5 Single, Married, Widowed, or Divorced. (Write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar. 7, 1928*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *William Stiffler*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Kaomi Smith*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *Chas. Williams, M.D.*15 *3-1928*16 *HAMPSON JONES, R.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 7 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*3-7*19 *27* to*3-7*19 *28*that I last saw her alive on *3-7* 19 *28*and that death occurred, on the date stated above, at *4:27 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia (toxic)*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy*(Signed) *Chas. Williams* M. D.3-7-1928 (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Commissioner Books**MAR 13 1928*

FBI - BALTIMORE



E 31602

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31602

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL* ST. *1-3* WARD)2-FULL NAME *Boy Seasey*(a) RESIDENCE No. *2725 Holan* ST. *City* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar. 5, 1928*

7 AGE

Years

Months

Days

If LESS than 1 day, *7* hrs. or *30* min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ind -*10 NAME OF FATHER *Will Seasey*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Anna*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) *Records*15 Filed *1928*

19

JOHNS HOPKINS HOSPITAL

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 5 - 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 5 - 1928*, to *March 5 - 1928*,that I last saw him alive on *March 5 - 1928*,and that death occurred, on the date stated above, at *11:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Prematurity*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Ellen Blossom*

M. D.

19

(Address) *The Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

*Commissioner Health.*

ADDRESS

MAR 13 1928

E 31603

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31603

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*)

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *1100 Madison Ave*

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed, or Divorced, (write the word)

*m*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Ellen Zeigler*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day... hrs.  
or... min.*47*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*N. C.*

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)*University Hospital*

Filed

19

*0221**RPN*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 7, 28, 19* to *March 6, 19 28*that I last saw him alive on *March 6, 19 28*and that death occurred, on the date stated above, at *2:15 P.M.*

The CAUSE OF DEATH\* was as follows:

*Lymphoid leukemia*(duration) yrs. *6* mos. ds.CONTRIBUTORY  
(Secondary)*(yes)?* (duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Blood examination*(Signed) *J. J. Jones*, M. D., 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND

19

20 UNDERTAKER

ADDRESS

*Wm. H. H. H. H.*

MAR 13 1928

E 31604

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31604

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 428 N. Payson St.

CITY OF BALTIMORE: (No. 70-27 ST., WARD)

2-FULL NAME Frank Ernest Filling.

(a) RESIDENCE NO. 428 N. Payson

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred 18 yrs. mos. ds.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Margaret Filling

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1868

7 AGE

59 Years

Months

60

Days

3

9

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Made electric signs

(b) General nature of industry, business, or establishment in which employed (or employer)

no work for 2 yrs.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER

Henry Filling

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Walter N. Filling  
Relay, Md.

15

Filed

19

HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1928

17

I HEREBY CERTIFY, That I attended deceased from February 2, 1928 to March 11, 1928, that I last saw her alive on March 11, 1928, and that death occurred, on the date stated above, at 8.25/1 p. m. The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of March 16, 1928

Was there an autopsy?

No. Personal &amp; Hall - 1003

What test confirmed diagnosis?

Clinical

(Signed)

Wm. A. Strauss

M. D.

3/11, 1928 (Address)

1201 Guffins Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Harrisburg, Pa.

DATE OF BURIAL

Mar 14, 1928

UNDERTAKER

ADDRESS

1003 West  
Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31605

## CERTIFICATE OF DEATH

44 E 31605

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 812 W Barre St. 21-29 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence A Busch(a) RESIDENCE NO. 812 W Barre St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Divorced5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Busch6 DATE OF BIRTH (month, day, and year) Oct 4 18817 AGE Years 46 Months 5 Days 8 IF LESS than 1 day.....hrs. or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Boat Engineer  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Baltimore Md10 NAME OF FATHER William Busch11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore Md12 MAIDEN NAME OF MOTHER Mary Clay13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14

Informant Mrs Edith R. Salomondt (sister)  
(Address) 812 W Barre St

15

1926 C. HAMPTON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 192817 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1928, to March 12, 1928that I last saw him alive on March 11, 1928and that death occurred, on the date stated above, at 530 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic valvular disease of the heart  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## CONTRIBUTORY

(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

if not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? no

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Edith Salomondt, M. D.3/12, 1928 (Address) 517 Leaden

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mrs. Elveth Ann

20 UNDERTAKER

John & Denny

Date of Burial

3/15/1928

ADDRESS

715 1/2 St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31606

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31606

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clinton W. Tutwiler(a) RESIDENCE NO. North River, Va St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married6a If married, widowed, or divorced HUSBAND of (or) WIFE of Malinda J. Tutwiler

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 54 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Va10 NAME OF FATHER B. H. Tutwiler11 BIRTHPLACE OF FATHER (city or town) (State or country) Va12 MAIDEN NAME OF MOTHER Ann Winkle13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va14 Informant Brother (Address)15 1928 C. HAMPTON JONES Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Peritonitis-ruptured gastric ulcer(Operation at hospital)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) John M. Jones M. D. (Coroner)3/13/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial

REMOVAL

20 UNDERTAKER

ADDRESS

Mt. Crawford Va Mar 13, 28  
Leon P. Fusselbaugh 26208 Paul

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31607

E 31607

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bank Ave. ST. 25<sup>th</sup> WARD)2-FULL NAME Katherine Schmeitzel(a) RESIDENCE NO. Bank Ave. ST. 25<sup>th</sup> WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 60 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mathias Schmeitzel

6 DATE OF BIRTH (month, day, and year)

Apr 16, 1847

7 AGE

80 Years81 Months10 Days26

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Mr. Geo. Parker  
Bank Ave. Baltimore

1928

C. HAMPTON JONES, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 12 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 1, 1928, to Mar 12, 1928.that I last saw her alive on Mar 11, 1928and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH\* was as follows:

apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Clinical signs

(Signed)

Thames Wheeler M.D.

(Address)

1212 E. Lombard, Baltimore, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Trinity CemeteryMarch 14 1928

20 UNDERTAKER

George J. SmithADDRESS 1532Hollins

E 31608

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31608

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Merex Hospital*St. *4-7* (Ward)2-FULL NAME *Lilly Grace Williams*(a) RESIDENCE NO. *Pocomok City, Maryland*

(Usual place of abode)

Ward

Length of residence in city or town where death occurred yrs. mos. *14* ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 Color or Race

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Dec. 24-1916*

7 AGE

Years

*11*

Months

*2*

Days

*18*

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School Girl*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Virginia*

10 NAME OF FATHER

*Frank Williams*

11 BIRTHPLACE OF FATHER (City or town) (State or country)

*Virginia*

12 MAIDEN NAME OF MOTHER

*Edna Anderson*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Virginia*

14

Informant (Address)

*Edna Anderson  
200 N. Chapel*

3 1928

*SAMPSON JONES*

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/13/28*

19

17

I HEREBY CERTIFY, That I attended deceased from

*2/28/28*

19

to *3/13/28*

19

that I last saw her alive on *3/13/28*

19

and that death occurred, on the date stated above, at *2 a.m.*

The CAUSE OF DEATH\* was as follows:

*Acute inflammatory  
Rheumatism*

(duration)

yrs. *4*

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. *2*

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

*Clinical*

(Signed)

*J. E. Winstead*

M. D.

19

(Address)

*Mary Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Pocomoke City Md.*

Date of Burial

*March 1928*

20 UNDERTAKER

*Philip Herwig*

ADDRESS

*206  
Orleans*

E 31609

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31609

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital.

2-FULL NAME Daisy S. Creswell.

(Residence in Baltimore: No. 130. W. 24th. Street.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 15 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female. 4-COLOR OR RACE, white. 5-SINGLE, MARRIED, \*married. WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Unknown, / 885. (Month) (Day) (Year)

7-AGE, 43. yrs. mon. da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. house work. (b) General nature of industry, business, or establishment in which employed (or employer). at home.

9-BIRTHPLACE, (State or Country), Maryland.

10-NAME OF FATHER, John J. Kelly. 11-BIRTHPLACE OF FATHER (State or Country), Unknown. 12-MAIDEN NAME OF MOTHER, Emma Moffitt. 13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Basil O. Creswell. (Husband) (Address) 3339. Paine, St.

15-

1928

HAMPSON JONES, R. P. N. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12th/1928. 1928. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry. (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7. da.

CONTRIBUTORY (Secondary)

(Signed) J. H. Walter M. D. (Coroner.)

3/13/28, 191... (Address) 508 E. Noryh Av...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. da. In the State. yrs. mos. da.

Where was disease contracted, if not at place of death?...

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, St. Marys cem Hampden.

DATE OF BURIAL, March 14/1928.

20-UNDERTAKER

J. Walter Davis 3307, Paine, St.

ADDRESS



31610

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31610

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 W 28th St 17-51 ST. 17-51 WARD)2-FULL NAME Samuel N. Young(a) RESIDENCE NO. 500 W 28th St 17-51 ST. 17-51 WARD(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Florence B. Young6 DATE OF BIRTH (month, day, and year) Jan 8, 18567 AGE 72 Years Months 1 Days 24 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) md.  
(State or country)10 NAME OF FATHER Charles T. Young11 BIRTHPLACE OF FATHER (city or town) md.  
(State or country)12 MAIDEN NAME OF MOTHER Mattilda Jane13 BIRTHPLACE OF MOTHER (city or town) md.  
(State or country)Informant Florence B. Young  
(Address) 500 W 28th St

1028

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1928HEREBY CERTIFY, That I attended deceased from Feb 28 to Mar 28that I last saw him alive on Mar 17 19 28and that death occurred, on the date stated above, at 5:50 m.

The CAUSE OF DEATH\* was as follows:

Exhaustion  
(duration) few days  
CONTRIBUTORY When shown  
(duration) acute  
(duration) acute18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed L. B. Johnson, M. D.  
19 28 (Address) 127 N 5th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Balto Cem  
ChenowethMarch 15, 1928  
3615 Chestnut

E 31611

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 31611

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1357 Under St. 24-25 WARD)

2-FULL NAME Michael Mullen

(a) RESIDENCE NO. 1357 Under St.

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 1 mos. 1 ds. ST., WARD (If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Kavanagh

6 DATE OF BIRTH (month, day, and year) July 7, 1900

7 AGE Years 27 Months 7 Days 24 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Ironwork

(c) Name of employer Campbell Metal Co.

9 BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Michael Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr. William Oliver (Address) 1309 Under St.

15 1928 C. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1928 to Mar. 11, 1928, that I last saw him alive on Mar. 11, 1928, and that death occurred, on the date stated above, at 8 pm.

The CAUSE OF DEATH\* was as follows:

Phthisis Pulmonalis.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Tuberculosis

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? over

(Signed) W. T. O'Leary, M. D.

3/13, 1928 (Address) 636 Fox Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill

20 UNDERTAKER

Chas. R. Stevens

DATE OF BURIAL

March 17, 1928

ADDRESS

1501 E. Fox Ave

E 31612

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31612

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3409 Walbrook Ave ST., 15-67 WARD)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2. FULL NAME D. Alexander Smith(a) RESIDENCE NO. 3409 Walbrook Ave ST., \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred — yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? 10 yrs. 10 mos. 10 ds.  
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Selina Marshall Smith6 DATE OF BIRTH (month, day, and year) March 21-18577 AGE Years Months Days If LESS than 1 day, hrs. or min.  
70 11 21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER Samuel R. Smith11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Margaret Bushman13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant Selina M. Smith  
(Address) 3409 Walbrook Ave15 3-1928 G. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 192817 I HEREBY CERTIFY, That I attended deceased from March 12, 1928, to March, 1928,  
that I last saw him alive on March 12, 1928,  
and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis(duration) about 3 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) arteriosclerosis  
(duration) 0 yrs. 0 mos. 0 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? — Date of —Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. B. Krite M. D.  
19 (Address) Elliott City Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmount Cem.Apr 15 1928

20 UNDERTAKER

ADDRESS

H. Allen Fuller3701 Callaway Ave

E 31613

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31613

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *809 Mulberry* ST. *18-70* WARD)2-FULL NAME *Richard J. Butler*(a) RESIDENCE No. *809 Mulberry* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Col**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 24-1913*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*15**2**18*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Schoolboy*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Butler*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Md.*

12 NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Md.*

Informant (Address)

*Josephine Butler 809 Mulberry St*

3-1928

G. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 17 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*June 10, 1927, to Mar 17, 1928.*that I last saw him alive on *Mar 17, 1928.*and that death occurred, on the date stated above, at *7 P. M.*

The CAUSE OF DEATH\* was as follows:

*Tubercular Disease Heart.*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? *NO* Date ofWas there an autopsy? *NO*What test confirmed diagnosis? *Chd. Exam.*(Signed) *DR. EDWARD J. JONES, M. D.*(Address) *1076 Edmondson*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVA

DATE OF BURIAL

20 UNDERTAKER

*W. S. Butler Co.**3/13/28**Hampton Jones**809 Mulberry St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31614

## CERTIFICATE OF DEATH.

129  
E 31614  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 207 Asquith St. 5-8 Ward)2-FULL NAME Harriett R. Owens(a) RESIDENCE NO. 207 Asquith

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

C.

5 Single, Married, Widowed, or Divorced, (write the word)

Widow5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofJohn Owens

6 DATE OF BIRTH (month, day, and year)

1841

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.87

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

BaltimoreMaryland

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

unknown

14

Informant

(Address)

Mrs. Emma V. Wood767 E. 24th New York

15 Filed.....

19

STAMPTON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28March 11

17

I HEREBY CERTIFY, That I attended deceased from

March 8, 1928, to March 11, 1928.that I last saw him alive on March 11, 1928.and that death occurred, on the date stated above, at 9 40 P. m.

The CAUSE OF DEATH\* was as follows:

Hemiplegia Cerebral(duration).....yrs. ....mos. 4.....ds.

CONTRIBUTORY

(Secondary)

Chronic Intestinal Nephrosis(duration) 5 yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed).....

Mar 13 1928 (Address) 508 Jones St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt Zion Cemetery3/14 1928

20 UNDERTAKER

ADDRESS

Mrs. Charles H. Bailey 14 21 Jefferson St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31615 DEATH

46 E 31615

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST. *13-52* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Miss Mary Brannan*(a) RESIDENCE NO. *3435 Roland Ave.* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *Mar. 1887*

AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

*41*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housekeeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*England*

10 NAME OF FATHER

*James Brannan*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Cath. Muller*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

*Anna Brannan 3435 Roland Ave.*

Filed

19

HAMPSON JONES, R. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-12* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *2-10*, 19 *28*, to *3-12*, 19 *28*.that I last saw him alive on *3-12*, 19 *28*.and that death occurred, on the date stated above, at *4 15 a.m.*

The CAUSE OF DEATH\* was as follows:

*General Carcinomatosis (ovary right & left)*CONTRIBUTORY (Secondary) *Acute Myocarditis* (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *yes* Date of *3/11/28*Was there an autopsy? *no*What test confirmed diagnosis? *Operation & Microscopic**Augustine P. Von Schuey, M.D.**St. Agnes Hos. - 8*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

*New Cathedral Cemetery May 15, 28*

20 UNDERTAKER ADDRESS

*H. S. Marshall 3539 Fell Road*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31616

## CERTIFICATE OF DEATH.

E 31616

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *464 N. Robinson* ST., *6-11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Joseph Nune*(a) RESIDENCE NO. *454 N. Robinson* ST., *6-11* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Child*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *No*6 DATE OF BIRTH (month, day, and year) *Mar 13, 1928*

7 AGE Years Months Days If LESS than 1 day, 5 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*10 NAME OF FATHER *Edward Nune*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Bertha Schuyler*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Md.*14 Informant (Address) *Edward Nune*  
*454 N. Robinson*

R 14 1928 HANCOCK JAMES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 13, 1928*17 I HEREBY CERTIFY That I attended deceased from *3-13-28* to *3-13-28* that I last saw him alive on *3-13-28*and that death occurred, on the date stated above, at *7:30* m.

The CAUSE OF DEATH\* was as follows:

*Drumstick Pill*CONTRIBUTORY (Secondary) *Alcohol Intoxication* (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Indisposed* (duration) yrs. mos. ds.Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Send to West Virginia* (Signed) *Wm. H. Hays, M. D.*19 State the Disease Causing Death, or in death, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) *800 N. D. H. Hays*19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Baltimore Cemetery* DATE OF BURIAL *Mar 14, 1928*20 UNDERTAKER *Elmer W. Coulter* ADDRESS *924 E. Eager St.*

E 31617

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31617

## 1. PLACE OF DEATH

CITY OF BALTIMORE, No. 1240 N. Carly ST. 16-23 WARD

## 2. FULL NAME

Joseph Kaufman

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1240 N. Carly ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

3/11/28

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

Joseph Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Hattie Schatz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt

14

Informant

(Address)

J. W. Kaufman 1240 N. Carly

15

Filed

14 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/13

1928

17

I HEREBY CERTIFY, That I attended deceased from

3/12

1928 to

3/13

1928

that I last saw him alive on

3/12

1928

and that death occurred, on the date stated above, at

8309 m.

The CAUSE OF DEATH\* was as follows:

Premature Birth of seven months

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

A. C. Hearn M. D.

(Address) 3907 Fairview Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Cross &amp; Co.

3/14/28

20 UNDERTAKER

ADDRESS

William Goehaefor

1816 Monument



*Hueghs*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 31618****CERTIFICATE OF DEATH.****90 E 31618****1-PLACE OF DEATH**City of BALTIMORE: (No. *2516 E. Fairmount* and *6-10* Ward)**2-FULL NAME***Mary E. Hueghs***(a) RESIDENCE NO.***2516 E. Fairmount*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

**PERSONAL AND STATISTICAL PARTICULARS****3 SEX***Female***4 Color or Race***White***5 Single, Married, Widowed, or Divorced, (write the word)***Married***5a If married, widowed, or divorced HUSBAND of (or) WIFE of***John S. Hueghs***6 DATE OF BIRTH (month, day, and year)***Aug. 18/1868***7 AGE**

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.*59**7**27***8 OCCUPATION OF DECEASED**

(a) Trade, profession or particular kind of work

*at Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9 BIRTHPLACE (city or town)***Balto.*

(State or country)

*Ind.***10 NAME OF FATHER***Patrick Veasey***11 BIRTHPLACE OF FATHER (city or town)**

(State or country)

*Ireland***12 MAIDEN NAME OF MOTHER***Mary E. Malone***13 BIRTHPLACE OF MOTHER (city or town)**

(State or country)

*Ireland***14**Informant *Mr. John S. Hueghs*

(Address)

*2516 E. Fairmount***15 Filed**

1928

*W. J. Jones, R.*

Registrar

**MEDICAL CERTIFICATE OF DEATH****16 DATE OF DEATH (month, day, and year)**

19

**17**

I HEREBY CERTIFY, That I attended deceased from

*Feb 1*, 1922, to *Mar 12*, 1928.

that I last saw him alive on

*Mar 12*, 1928.and that death occurred, on the date stated above, at *9:50 p.* m.

The CAUSE OF DEATH\* was as follows:

*Heart Disease Heart*

(duration) ..... yrs. .... mos. .... ds.

**CONTRIBUTORY**

(Secondary)

*Chronic Val Heart Disease*

(duration) ..... yrs. .... mos. .... ds.

**18 Where was disease contracted**

If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *B. H. May, M. D.*1/13, 1928 (Address) *1524 E 33rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

**19 PLACE OF BURIAL, CREMATION OR REMOVAL**

Date of Burial

*Western View**March 16 1928***20 UNDERTAKER**

ADDRESS

*John J. Herr 156 N. Luzerne*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31619

## CERTIFICATE OF DEATH.

E 31619

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2806 Kentucky ST. 8-45 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Grant(a) RESIDENCE NO. 2806 Kentucky PT. 8-45 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 11/28

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Yes

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER James Grant11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore12 MAIDEN NAME OF MOTHER Anna Belosky13 BIRTHPLACE OF MOTHER (city or town) (State or country) BaltimoreInformant (Address) James Grant2806 Kentucky

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1928

## 17

I HEREBY CERTIFY, That I attended deceased from Mar 11, 1928, to Mar 13, 1928.that I last saw her alive on Mar 12, 1928.and that death occurred, on the date stated above, at 5 AM

The CAUSE OF DEATH\* was as follows:

Congenital Heart Trouble(duration) yrs. mos. ds. 2

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Rydman, M. D.

Mar 13/28 801 N. Howard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Holy Redeemer Mar 14 1928

## UNDERTAKER

## ADDRESS

102 J. Vernon 156 Eugene

AR 14 1928 HAYSON JONES, R. Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31620

## CERTIFICATE OF DEATH.

E 31620

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 N WolfeST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Malone(a) RESIDENCE NO. 814 N Wolfe

(Usual place of abode)

ST., \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred Life yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE C5 Single, Married, Widowed, or Divorced, (write the word) Widow6a If married, widowed, or divorced Widow  
or) WIFE of Earle MaloneDATE OF BIRTH (month, day, and year) Aug 28 1888

AGE

Years 39Months 7Days 13If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) Baltimore  
(State or country) MD10 NAME OF FATHER John Connolly11 BIRTHPLACE OF FATHER (city or town) MD  
(State or country)12 MAIDEN NAME OF MOTHER Elizabeth W. Plow13 BIRTHPLACE OF MOTHER (city or town) MD  
(State or country)Informant Mary Morton (sister)  
(Address) 814 N Wolfe

Filed \_\_\_\_\_

19 \_\_\_\_\_

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Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1928

17

I HEREBY CERTIFY, That I attended deceased from Oct, 1928, to March 11, 1928.that I last saw him alive on March 10, 1928,  
and that death occurred, on the date stated above, at 6:35 A.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma Breast  
(Primary)(duration) \_\_\_\_\_ yrs. 6 mos. \_\_\_\_\_ ds.CONTRIBUTORY Hypostatic Pneumonia  
(Secondary)(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.18 Where was disease contracted  
if not at place of death? unknownDid an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) R. J. Goss3/11/28 (Address) 1424 E. Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
INTERMENT Wetzel CemeteryDATE OF BURIAL Mar. 14 192820 UNDERTAKER Chris. N. JohnsonADDRESS 16 N. Caroline

E 31621

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *212 S. Duncan* ST. *13* WARD)2-FULL NAME *Josephine E. Johnson*(a) RESIDENCE NO. *212 S. Duncan* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *Apr. 4 - 1917*AGE Years \_\_\_\_\_ Months *11* Days *7* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_BIRTHPLACE (city or town) *Baltimore*  
(State or country) \_\_\_\_\_10 NAME OF FATHER *Lloyd Johnson*11 BIRTHPLACE OF FATHER (city or town) *Dem.*  
(State or country) \_\_\_\_\_12 MAIDEN NAME OF MOTHER *Della Burns*13 BIRTHPLACE OF MOTHER (city or town) *Balto*  
(State or country) \_\_\_\_\_Informant *Della Johnson*  
(Address) *212 S. Duncan St.*Filed *14 1928* Registrar *R. J. H.*

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 12 1928*17 I HEREBY CERTIFY that I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* find that said deceased came to *his* death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Cap. Bronchitis*CONTRIBUTORY (Secondary) *Exhaustion* (duration) yrs. \_\_\_\_\_ mos. *2* ds. \_\_\_\_\_(Signed) *M. G. C. Blady* M. D. (Address) *1328 N. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., \_\_\_\_\_ mos., \_\_\_\_\_ ds. In the State yrs., \_\_\_\_\_ mos., \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Greenwood Cemetery* DATE OF BURIAL *Mar. 14 1928*UNDERTAKER *Chas. H. Johnson* ADDRESS *417 N. Caroline St.*





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31623

## CERTIFICATE OF DEATH.

199 E 31623

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Colinet Hosp 15-23* St. *15-23* Ward)2-FULL NAME *Richard Morris Jr.*(a) RESIDENCE NO. *1457 N. Carey* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *12* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

*Male Colored*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1916*

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

*2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town)

(State or country)

*Maryland*10 NAME OF FATHER *Richard Morris*

PARENTS

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Virginia*12 MAIDEN NAME OF MOTHER *Margaret Haller*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Maryland*

14

Informant (Address) *Margaret Morris 1457 N. Carey St*

15 Filed

*AR 14 1928*Registrar *W. H. C.*

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 13 1928*17 I HEREBY CERTIFY That I took charge of the remains described above, held an *Autopsy* (Inquest, autopsy or inquiry.)There was no evidence obtained by said *Autopsy* and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH was as follows:

*Homicide  
Haemorrhage of Brain  
Multiple Gun Wounds*

CONTRIBUTORY (Secondary)

*Mar 9 1928* (duration) *4 hrs* (Signed) *W. H. C.* (Coroner) (Address) *143 N. Carey*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*Mt Auburn Mar 15 1928*  
UNDERTAKER *Virginia A. Brooks* ADDRESS *1413 N. Carey*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31624

## • CERTIFICATE OF DEATH

38 E 31624

1-PLACE OF DEATH

Colonial Hospital

REGISTERED NO.

City of BALTIMORE: (No.

1122 N. Mount St., 16-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ruth Boyer

(a) RESIDENCE NO.

1434 Harlem Ave

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S. if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Nathaniel Boyer

6 DATE OF BIRTH (month, day, and year)

July 13 - 1898

7 AGE

29 30 yrs

Years

Months

Days

IF LESS than  
1 day hrs.  
or min..

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

10 NAME OF FATHER

Moses Alton

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Annie Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

Nathaniel Boyer

(Address)

1434 Harlem Ave.

15 Filed

C. HAMPTON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 12<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from

3-8, 1928, to 3-12, 1928

that I last saw her alive on March 11<sup>th</sup>, 1928and that death occurred, on the date stated above, at 15<sup>00</sup> A. M.

The CAUSE OF DEATH\* was as follows:

Nephritis

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death?

no

Date of

Was there an autopsy?

yes

What test confirmed diagnosis?

Blood Chemistry

(Signed)

Julius Brulow, M. D.

19

(Address) Colonial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt. Auburn Cemetery

3/14 1928

UNDERTAKER

Thomas G. Nelson

ADDRESS

1303 Kressman

Very important. See instructions on back of certificates.

PARENTS

MAR 14 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31625

## CERTIFICATE OF DEATH.

E 31625

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1020 Gilman St., 16-22 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie Matthews(a) RESIDENCE NO. 1020 Gilman St., \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race colored5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced HUSBAND of \_\_\_\_\_ (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE

Years 43

Months \_\_\_\_\_

Days \_\_\_\_\_

IF LESS than 1 day.....hrs. \_\_\_\_\_ or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer \_\_\_\_\_

## 9 BIRTHPLACE (city or town)

(State or country) Balto Md.10 NAME OF FATHER William Matthews

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va12 MAIDEN NAME OF MOTHER Pocalla Berry

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

PARENTS

14 Informant (Address) Nettie Matthews  
1020 Gilman

15 Filed \_\_\_\_\_, 19 \_\_\_\_\_

Registrar W. H. H.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Indigestion  
Cross of Dist

CONTRIBUTORY

W. H. H.1319143101Bury

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mathuram cemetery

Date of Burial

3/15 1928

20 UNDERTAKER

Thomas G. Kelson

ADDRESS

1303  
Presidents



E 31626

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31626

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 N Greene ST. 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta W Carlisle(a) RESIDENCE NO. 230 N Greene

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred 81 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widow6a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph W Carlisle7 DATE OF BIRTH (month, day, and year) Dec 23 18468 AGE Years 81 Months 2 Days 19 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md10 NAME OF FATHER Alfred Armstrong11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md12 MAIDEN NAME OF MOTHER Holland13 BIRTHPLACE OF MOTHER (city or town) (State or country) MdInformant James F Armstrong (Address) 230 N Greene StFiled 1928 G. E. JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1928

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1928, to March 12, 1928, that I last saw him alive on March 12, 1928

and that death occurred, on the date stated above, at \_\_\_\_\_

The CAUSE OF DEATH\* was as follows:

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ernest H. Palmer M. D.3/13 1928 (Address) 3005 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Park CemMar 14 1928

UNDERTAKER

ADDRESS

W W Routson230 N Greene

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31627

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1528 Gorsuch Ave* ST. *129* WARD)2-FULL NAME *Frederick Watts Dutton*(a) RESIDENCE NO. *1528 Gorsuch Ave*  
(Usual place of abode)Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Louisa A Dutton*7 DATE OF BIRTH (month, day, and year) *Dec 6, 1887*

8 AGE

Years *90*Months *3*Days *6*If LESS than  
1 day, hrs  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Ship Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Malsted & Co*BIRTHPLACE (city or town)  
(State or country) *Balt Md*10 NAME OF FATHER *John R Dutton*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Balt Md*12 MAIDEN NAME OF MOTHER *Sarah Watts*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Balt Md*Informant  
(Address) *Malsted & Co  
1528 Gorsuch Ave*

Filed

10

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 12 1928*

17

I HEREBY CERTIFY, That I attended deceased from *several years*, 19 *March 12*, 19 *28*,  
that I last saw him alive on *March 12*, 19 *28*,  
and that death occurred, on the date stated above, at *9:10 P. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Intestinal Neoplasm &  
Infermitas of ag*(duration) *several* yrs. mos. ds.CONTRIBUTORY  
(Secondary) *Infermitas*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical & Chemical*  
(Signed) *R. D. Carman*, M. D.5-12-1928 (Address) *1701 N Caroline St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

ADDRESS

631628, HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *117* *631628*)

## 2-FULL NAME

(a) RESIDENCE NO. *147* *Wilkins* St. *117* *631628*

(Usual place of abode)

Length of residence in city or town where death occurred *42* yrs. *6* mos. *23* ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 Color or Race

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Angusta Jester*

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years *42* Months *6* Days *23*

IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Yardman*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country) *Md.*

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

PARENTS

14

Informant (Address) *Hospital Records*

1928

Per

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from *March 6, 1928*, to *March 14, 1928*.that I last saw him alive on *March 14, 1928*.and that death occurred, on the date stated above, at *4:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Appendicitis*

## CONTRIBUTORY (Secondary)

(duration) yrs. *18* mos. ds.*Misinteric thrombosis**& Pulmonary embolism*(duration) yrs. mos. *6 hrs.* ds.

## 18 Where was disease contracted

If not at place of death? *Home*Did an operation precede death? *Yes*, Date of *3-13-28*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## PLACE OF BURIAL, CREMATION OR

Date of Burial

## 2. UNDERTAKER

ADDRESS





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31630

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 E. Lombard

ST. 3 WARD)

2. FULL NAME Sam Jarasolinsky

(a) RESIDENCE NO. 2212 E. Lombard

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

ST., WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 20 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced  
HUSBAND of  
or WIFE of

Hertie Jarasolinsky

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

55

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Person

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Clothing

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Russia

14 Informant  
(Address)J. Lewis  
1439 E. Balt. St.

15 Filed

1928, J. H. Jones, M. D.  
Registrar

REGISTERED NO.

E 31630

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
Oct 1927 to Jan 13 1928that I last saw him alive on Mar 11 1928  
and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Pulmonary TB

(duration) 3 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam  
(Signed) A. T. Rice, M. D.

Mar 11, 1928 (Address) 24 E. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Rehman Ind Carmel  
Joan Lewis 1439 E. Balt. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31631

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 402 S. Stricker St., 19-28 Ward)

Registered No. 31631

2-FULL NAME Freda W. Frank

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 402 S. Stricker St., Ward

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S. if of foreign birth? 43 yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-Single, Married, Widowed, Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sep 25 1883

7-AGE, 44 yrs. 5 mos. 14 ds. If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work, House work (b) General nature of industry, business, or establishment in which employed (or employer), (c) Name of employer,

9-BIRTHPLACE (city or town), (State or Country), Germany

10-NAME OF FATHER, Ernest W. Frank

11-BIRTHPLACE OF FATHER (city or town), (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Ottilie Kraining

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Germany

4- (Informant), Mrs. Ernest Frank (Address), 402 S. Stricker St.

R 14 1928 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year), March 11 1928

17- I HEREBY CERTIFY, That I attended deceased from July 27 1928, to March 11 1928.

that I last saw her alive on March 10 1928.

and that death occurred, on the date stated above, at 11:15 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Nephritis

Uraemic Convulsion

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. 1 hr.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Bulant, M. D.

March 13, 1928 (Address) 2406 Pa. Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park DATE OF BURIAL, Mar. 14, 1928

20-UNDERTAKER, Harry J. Witzke ADDRESS, 1531 W. Lombard St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31632

## CERTIFICATE OF DEATH

E 31632

## 1-PLACE OF DEATH

City of BALTIMORE (No. *Found dead hanging to Telephone pole in rear 1528 Hollins St.*)

## 2-FULL NAME

(a) RESIDENCE NO. *1512 Hollins* St. *Ward*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 Color or Race

*White*

## 5 Single, Married, Widowed, or Divorced. (write the word)

*Married*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Caroline Delcher*

## 6 DATE OF BIRTH (month, day, and year)

*Oct 18 - 1848*

## 7 AGE

Years

Months

Days

*79**5**4*IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Retired*

## 9 BIRTHPLACE (city or town)

(State or country)

*Balto*

## 10 NAME OF FATHER

*Geo. Delcher*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Balto*

## 12 MAIDEN NAME OF MOTHER

*Margaret Johnson*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto*

## 14

Informant  
(Address)*Mrs C. Delcher  
1512 Hollins St*

## 15 Filed....., 19

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 12 1928*

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Suicide by Hanging  
Strangulation and strangulation*  
(duration.....yrs. mos. ds.)CONTRIBUTORY  
(Secondary)*Wm B. Norton*  
Signed *Wm B. Norton* M. D.  
13-1928 (Address) *Curtis Bay*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See instructions for medical examiners.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. mos. ds. In the State.....yrs. mos. ds.  
Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Loudon Park*  
20 UNDERTAKER  
*Harry H. Witzke**Mar 15 1928*

ADDRESS

*1531 W. L. Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31633

E 31633

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 N. Chester St. ST. 23-31 WARD 93)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Burk

(a) RESIDENCE NO. 928 Hanover St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Mar 5 1877

AGE Years Months Days If LESS than 1 day, hrs. or min. 51 0 7

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Martin Burk

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Eliz. Willershauser, 19 (Address) 1300 E. Charles

13 BIRTHPLACE OF MOTHER (city or town) Ger. (State or country)

Informant Mrs. Zimmerman (Address) 928 Hanover St.

Filed 14 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 14 1928 to Mar 12 1928, that I last saw him alive on 3/12 1928

and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Embolism

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Venous ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. F. M. Conly, M. D.

(Address) 1300 E. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

S. F. M. Conly

1300 E. Fort



E 31634

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31634

## CERTIFICATE OF DEATH.

10-002

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1261 Riverside ave. 24-23

## 2-FULL NAME Shirley Louise Aldrich

(a) RESIDENCE NO. 1261 Riverside ave.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20, 1923

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

6

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Wayne E. Aldrich

11 BIRTHPLACE OF FATHER (city or town) N.Y. (State or country)

12 MAIDEN NAME OF MOTHER Bertrude McGunney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14

Informant (Address) Bertrude Aldrich 1261 Riverside ave

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March, 13 1928

17

I HEREBY CERTIFY, That I attended deceased from 3/11, 1928, to 3/13, 1928, that I last saw her alive on 3/13, 1928, and that death occurred, on the date stated above, at 11:30 a.m. The CAUSE OF DEATH\* was as follows:

Diphtheria

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary) Myocarditis (acute degeneration)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings - (Signed) James Brown M. D.

(Address) Medical Arts Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-BURIAL

DATE OF BURIAL

Garden Hill Cem. March 14, 1928

20 UNDERTAKER

ADDRESS

New McQuilly

130 E Port Ave.

E 31635

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31635

1-PLACE OF DEATH *Union Memorial Hospital*

REGISTERED NO.

CITY OF BALTIMORE: (No. *33rd + Calvert* ST. *12-49* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Miss Sally Peck*(a) RESIDENCE NO. *8 Gloucester*ST. *Benton Mass.* WARD

Length of residence in city or town where death occurred

mos. *?*

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>W</i>	5 Single, Married, Widowed, or Divorced, (write the word) <i>Single</i>
------------------------	-----------------------------	--

(a) If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *Oct 9, 1912*

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<i>15</i>		<i>5</i>	<i>5</i>	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Student*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *New Jersey*  
(State or country)10 NAME OF FATHER *Theodore Peck (d)*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *New Jersey*12 MAIDEN NAME OF MOTHER *Clara Ray (d)*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Wisconsin*Informant *School Nurse, at*  
(Address) *Oldfield School*R 14 1928  
Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 14 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Mar. 12, 1928, to Mar. 14, 1928,*  
that I last saw her alive on *Mar. 14, 1928,*  
and that death occurred, on the date stated above, at *10:45 A. M.*

The CAUSE OF DEATH\* was as follows:

*acute Endocarditis (staphylococcus)  
with septicemia*(duration) yrs. mos. *?* ds.CONTRIBUTORY *Congenital Malformation of*  
(Secondary) *Heart*, (duration) *Life* mos. ds.18 Where was disease contracted  
if not at place of death? *at Oldfield School*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical Signs, Laboratory*  
(Signed) *W. J. Jenkins*, M. D., 19 (Address) *Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Morristown N. J.*

20 UNDERTAKER

*Henry H. Jenkins Sons*

DATE OF BURIAL

*Mar 15 1928*

ADDRESS

*McCallah  
+ Orchard*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31636

## CERTIFICATE OF DEATH.

31636

1-PLACE OF DEATH *Alhambra Apt. 28*  
 CITY OF BALTIMORE: (No. *Residence* ST. *13-59* WARD)  
 2-FULL NAME *Henry Clarke*  
 (a) RESIDENCE NO. *Alhambra Apt. 28* ST. *13-59* WARD  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *7* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *70* yrs. *0* mos. *0* ds.  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced  
 HUSBAND of *Lena Hoffman Clarke*  
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 10, 1842*

7 AGE Years *85* Months *10* Day *3* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired merchant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Krotoschein*  
 (State or country) *Germany*

10 NAME OF FATHER *Asron Clarke*

11 BIRTHPLACE OF FATHER (city or town)  
 (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Fala Israel*

13 BIRTHPLACE OF MOTHER (city or town)  
 (State or country) *Germany*

14 Informant *Emil Clarke (son)*  
 (Address) *Emersonian Apt.*

15 Filed *1928* REGISTRAR *[Signature]*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 13, 1928*

17 I HEREBY CERTIFY, That I attended deceased from *July*, 19*25*, to *March*, 19*28*, that I last saw him alive on *March 13*, 19*28*, and that death occurred, on the date stated above, at *1 A. m.*

The CAUSE OF DEATH\* was as follows:

*Arterio-sclerosis*  
*Hemiplegia*

(duration) *11* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary) *Myocardial insufficiency* (duration) *3* yrs. *0* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *No special test*  
 (Signed) *[Signature]* M. D.

*3-13, 1928* (Address) *1107 St. Paul St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
 MOVAL *Balts. Hebrew Cem.*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*David Sondheim* *3/15/28*  
*1820 W. Mt. Royal Ave.*

E 31637

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31637

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1116 Ohio* ST. *23-31* WARD)2-FULL NAME *Hillard Baskerville*(a) RESIDENCE NO. *1116 Ohio St.* ST. *23-31* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *34* yrs. mos.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male Colored Single*  
6a If married, widowed, or divorced HUSBAND of (or) WIFE of7 DATE OF BIRTH (month, day, and year) *March 6 1925*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

4

Informant (Address)

Filed

19

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 12 1925*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 6 1925, to Mar. 12 1925.*that I last saw him alive on *March 12 1925.*and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH\* was as follows:

*Acute Septicemia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *urine test*(Signed) *J. L. Shelton*, M. D.Address) *1305 N. Gilman St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Mr. George M. Jones, 118 W. 17th St.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31638 OF DEATH

REGISTERED NO. E 31638City of BALTIMORE: (No. University Hospital St. 4-30 Ward)2-FULL NAME Emma Solomon(a) RESIDENCE NO. Sumdalk, Md St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles B. Solomon6 DATE OF BIRTH (month, day, and year) Jan 12 - 19047 AGE Years 24 Months 2 Days 0 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) Balto Co Md10 NAME OF FATHER Edw. G. Kankhoff11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) Germany12 MAIDEN NAME OF MOTHER Martha Platt13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) Germany14 Informant Edw. G. Kankhoff (Address) Sumdalk, MdFiled MAR 14 1928 Registrar McCall

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Puerperal Septicemia(duration) \_\_\_\_\_ yrs. 2 mos. 11 ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Signed) George W. Zirkler M. D. (Coroner)3/4, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

First Evangelical Cem.UNDERTAKER George W. Zirkler

Date of Burial

3/16 1928

ADDRESS

1737 E. Esqu

E 31639

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital 26-37* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *3707 O'Donnell* Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)*Male**White**Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*July 7-1883*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.*44**8**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*laborer*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore, Md.*

10 NAME OF FATHER

*Henry Zimmerman*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Margaret Klein*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant

(Address)

*Fred. Zimmerman**5107 O'Donnell St.*

15

Filed

19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 11 1928*

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

*Gun shot wound of Chest*

CONTRIBUTORY

(Secondary)

*Mar 13/28* *Gunshot wound of Chest**1437 W. Bay*

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

*Mt. Carmel Cemetery**3/15 1928*

20 UNDERTAKER

ADDRESS

*George W. Zirkler**1737 E. Eager St.*

E 31640

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31640

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *702 S. Third*)ST. *26-37* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles H. Becker, Jr.*(a) RESIDENCE NO. *702 S. Third*

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. mos.

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *May 28-1927*AGE Years Months Days *15* If LESS than 1 day, hrs or min. *14*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*10 NAME OF FATHER *Charles H. Becker*11 BIRTHPLACE OF FATHER (city or town) *Balto., Co., Md.* (State or country)12 MAIDEN NAME OF MOTHER *Augusta W. Mack*13 BIRTHPLACE OF MOTHER (city or town) *Balto., Md.* (State or country)Informant *Charles H. Becker* (Address) *702 S. Third St.*Filed *19* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/13* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from

*3/6*, 19 *28*, to *3/13*, 19 *28*that I last saw him live on *3/13*, 19 *28*and that death occurred, on the date stated above, at *6:30* P. m.

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? *no*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Ch. K. Schunder*, M. D.*3/14*, 19 *28* (Address) *2439 Eastern Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Mt. Carmel Cem.*

DATE OF BURIAL

*3/16* 19 *28*

20 UNDERTAKER

*George W. Zirkler*

ADDRESS

*1737 E. Egan St.*

Spec. 1-12-23

31641

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817-6th, Brooklyn ST. 15-15 WARD)

## 2-FULL NAME John Henline Henline

(a) RESIDENCE NO. 817-6th

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred 11 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Henline

DATE OF BIRTH (month, day, and year) Sept 3, 1859

AGE

Years 68

Months 6

Days 9

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md Henline

10 NAME OF FATHER John Henline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Ludwig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Laura Henline 817-6th St

Filed

14 1928

HARRISON JONES, R. U. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1928, to Mar 12, 1928, that I last saw him alive on Mar 10, 1928, and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH was as follows:

Gastric Carcinoma

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray

(Signed) P. Gustor DeLano

2/14/28 (Address) 1509 W Lombard St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St Johns Cemetery

DATE OF BURIAL

3/15 1928

ADDRESS 502 N. York St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31642

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3336 Gwynn's Falls Pkwy. WARD 15-67)

## 2-FULL NAME

Asa Van Tassell

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3336 Gwynn's Falls Pkwy. WARD 15-67  
(Usual place of abode)Length of residence in city or town where death occurred 95 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofAdelaide S. Van Tassell6 DATE OF BIRTH (month, day, and year) Aug. 17-18657 AGE Years 62 Months 6 Days 25 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

Eisenberg's

(c) Name of employer

Dept Store

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

David Van Tassell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York

12 MAIDEN NAME OF MOTHER

Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

New York

14 Informant

(Address) C. A. Van Tassell  
3336 Gwynn's Falls Pkwy.

15

1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13-1928

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1928, to March 13, 1928, that I last saw him alive on March 13, 1928, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH\* was as follows:

Double pneumonia, lobar,(duration) yrs. mos. 10 ds.CONTRIBUTORY Was 25% overweight, with  
(Secondary) high pressure (duration) Several mos. ds.18 Where was disease contracted if not at place of death? Not knownDid an operation precede death? No Date of XWas there an autopsy? NoWhat test confirmed diagnosis? No special one,(Signed) O. W. Hoffman, M. D.3.3.1928 (Address) 2500 Garrison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenwood Cem Brooklyn3/16 1928

20 UNDERTAKER

ADDRESS

Chas. P. Tracey & Son 118 Mont Royal Ave

E 31643

## HEALTH DEPARTMENT—CITY OF BALTIMORE, E 31643

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3805 Larranda Ave* ST. *15-58* WARD)2. FULL NAME *Israel B. Fisher*(a) RESIDENCE No. *3805 Larranda Ave* ST. *15-58* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *47* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? *47* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*If married, widowed, or divorced  
HUSBAND or WIFE of *Dora Fisher*DATE OF BIRTH (month, day, and year) *unknown*AGE Years *58* Months *—* Days *—* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Cabinet Maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Louis Fisher*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Hammoh*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*Informant *Dora Fisher*  
(Address) *3805 Larranda Ave*

1928

HAMPSON

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/13* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *March 12*, 19 *28*, to *March 13*, 19 *28*, that I last saw him alive on *March 13*, 19 *28*, and that death occurred, on the date stated above, at *3 P* m.

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Baltimore*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *examination*(Signed) *Jack C. Coker* M. D.*3/14, 1928* (Address) *2235 Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Heaven Rose Dale*

UNDERTAKER

*Jack Louis 1439 E. 30th St.*

DATE OF BURIAL

*3/25/28*

ADDRESS

31644

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31644

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Evesham, GovansST. 45 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Bordley Clemens

## (a) RESIDENCE NO.

Evesham, Govans

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

75 yrs. 10 mos. 16 ds.

How long in U. S., if of foreign birth?

-- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Augustus D. ClemensDATE OF BIRTH (month, day, and year) May 29, 1852

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

751016

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

BaltimoreMaryland10 NAME OF FATHER Wm. Clayton Bordley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland12 MAIDEN NAME OF MOTHER Amelia Heritage

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

Informant

Mrs. Retta A. Hyde

(Address)

Evesham, Govans

4 1928

HAMPSON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13 1928

17

I HEREBY CERTIFY, That I attended deceased from 12 -, 1926, to 3-12 -, 1928.that I last saw her alive on 3-12 -, 1928and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Colon  
(Transverse + Descending,  
Splenic Flexure)  
about (duration) 1 yrs.  mos.  ds.

CONTRIBUTORY (Secondary)

old Mitral Insufficiency  
(duration) 20 yrs. 7 mos.  ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes Date of Nov. 29 1927

Was there an autopsy?

No

What test confirmed diagnosis?

Pathological specimen

(Signed)

H. Tunstall Taylor, M. D.2/14, 1928 (Address)11 Overhill Road.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. John's Cem. Waverly3/15 1928

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son, 805 N. Calver





31646

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31646

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Square Hospital* 179  
 CITY OF BALTIMORE: (No. *100 Calhoun* 21-29 WARD)  
 2-FULL NAME *Albert Lufrio*  
 (a) RESIDENCE NO. *3148 Poppleton* WARD  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *3* yrs. *1* mos. *13* ds. (If non-resident give city or town and State)  
 Not long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 31 - 1928*

7 AGE Years *3* Months *1* Days *13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto md*  
 (State or country)

10 NAME OF FATHER *Wm F Lufrio*

11 BIRTHPLACE OF FATHER (city or town) *md*  
 (State or country)

12 MAIDEN NAME OF MOTHER *Lena W Seifert*

13 BIRTHPLACE OF MOTHER (city or town) *md*  
 (State or country)

14 Informant *Wm W F Lufrio*  
 (Address) *319 So Poppleton*

15 *4 1928* *C. HAMMON JONES* Registrar

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH (month, day, and year) *March 13 1928*

HEREBY CERTIFY, That I attended deceased from

*3-12-1928* to *3-13-1928*

that last saw him alive on *3-13-1928*

and that death occurred, on the date stated above, at *8:45 A m.*

The CAUSE OF DEATH\* was as follows:

*Second and third degree burns (scalded)*

(duration) yrs. mos. *1* ds.

CONTRIBUTOR (secondary) *Toxemia*

(duration) yrs. mos. *1* ds.

16 Where was disease contracted *Home*

if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Examination*

(Signed) *Louis H. Toller* M. D.

, 19 (Address) *Franklin Square Hosp. Balto md*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*St Peters Cemetery* *APR 15 - 1928*  
*John J. Bowman & Son* *401 Hollins*

E 31647

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31647

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 553 W BONE ST. 27-20 WARD)2-FULL NAME Annie P. Cooney

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 553 W BONE ST. 27-20 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 7 mos. " ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced HUSBAND or (or) WIFE of Matthew J. CooneyDATE OF BIRTH (month, day, and year) Aug 2<sup>nd</sup> 1878AGE Years Months Days If LESS than 1 day, hrs. or min. 49 7 "

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.10 NAME OF FATHER Timothy Walsh11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER Annie O'Reilly13 BIRTHPLACE OF MOTHER (city or town) (State or country) IrelandInformant Mrs. Annie Walsh (Address) 3 W Bone StFiled 1928

19

HAMPSON JAMES H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 - 192817 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to, Mar 13, 1928, that I last saw her alive on Mar 12, 1928and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH\* was as follows:

Chr. Interstitial Nephritis(duration) 5 yrs. mos. ds.CONTRIBUTORY (Secondary) Myocarditis(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Urinary tests (Signed) John Delivet M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Baltimore Cem. Mar 16, 1928

20 UNDERTAKER

ADDRESS

John J. Bowman & Sons 40 N. Holliday

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 31648

## CERTIFICATE OF DEATH

101-00 ✓  
E 31648

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Provident Hospital*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *129 Unruh St.*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*M* *ed* *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

*24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Laborer*

9 BIRTHPLACE (city or town)

(State or country)

*B W D*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filed

1928

*C. HARRISON JONES*  
*RR 74*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 2, 1928* to *Mar. 12, 1928*that I last saw him alive on *Mar. 12, 1928*and that death occurred, on the date stated above, at *7:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*John W. Langer, M. D.**Provident Hospital*

\*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

Commissioner Health.

ADDRESS

Wm. B. WOODALL

MAR 14 1928

HEALTH DEPARTMENT—CITY OF BALTIMORE E 31649

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Sargeant ST. 21-29 WARD)2-FULL NAME Walter G. Brewer,(a) RESIDENCE NO. 1117 Sargeant ST. 21-29 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Divorceda If married, widowed, or divorced HUSBAND of Lillian Brewer (or) WIFE ofDATE OF BIRTH (month, day, and year) Apr 15 1914AGE 53 Years 10 Months 28 Days If LESS than 1 day, hrs. or min. 54

## OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work Labr.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John Hopkins Hosp.BIRTHPLACE (city or town) Md. (State or country)10 NAME OF FATHER John M. Brewer11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)12 MAIDEN NAME OF MOTHER Ann C. Martin13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)Informant Mr. Fred. Brewer (Address) 1117 Sargeant St.Filed 19 Registrar John J. Bowman

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 192817 I HEREBY CERTIFY, That I attended deceased from 3/8, 1928, to 3/13, 1928,that I last saw him alive on 3/13, 1928,and that death occurred, on the date stated above, at 9:25 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma Stomach & Rectum(duration) 1 yrs. 0 mos. 0 ds.

## CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/13/28Was there an autopsy? YesWhat test confirmed diagnosis? I H Hsp report(Signed) Timothy J. Tully M. D.Address 910 W. L. Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIALNew Catholic Cemetery Mar. 16 192820 UNDERTAKER John J. Bowman ADDRESS 4018 E. Baltimore



E 31650

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31650

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (Not)

## 2. FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)5a Married, widowed, or divorced  
HUSBAND of  
(or WIFE of)

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

24 Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

4 1928

5

19

HARRISON JONES, R. D.

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 26, 1928, to Mar 12, 1928.

that I last saw him alive on Mar 12, 1928.

and that death occurred, on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)  
Chronic Interstitial  
Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Street, M. D.

445 E. Fox Ave

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31651

## CERTIFICATE OF DEATH.

E 31651

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1805 E. Lafayette Ave St. 8-17 Ward)2-FULL NAME Franklin Stevenson Burgan(a) RESIDENCE NO. 1805 E. Lafayette Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) widowed5a If married, widowed, or divorced  
HUSBAND of Elizabeth A. Burgan  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year)  
April 4-18547 AGE Years 73 Months 11 Days 10 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant(b) General nature of industry, business, or establishment in which employed (or employer) 645

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Baltimore Co., Maryland.  
(State or country)10 NAME OF FATHER Thomas Burgan11 BIRTHPLACE OF FATHER (city or town) Baltimore Co., Maryland.  
(State or country)12 MAIDEN NAME OF MOTHER Jane Lee13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co., Md.  
(State or country)14 Informant Lulu Thomsen.  
(Address) 4423 Forest View Ave.

1928

RAMPSON JONES, R. D.  
Registrar

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14-1928.17 I HEREBY CERTIFY, That I attended deceased from July 10-, 1927, to March 14-, 1928, that I last saw him alive on March 13-, 1928, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhages(duration) 1 yrs. — mos. — ds.CONTRIBUTORY none.

(Secondary)

(duration) No. yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? physical signs & symptoms(Signed) Chester Ireland, M. D.2-14-1928 (Address) 2532 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Baltimore Cemetery March 16 1928

20 UNDERTAKER

ADDRESS

John Mitchell 1900 Centre Place

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31652

## CERTIFICATE OF DEATH

REGISTERED NO. 99-081 E 31652

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 716 N. Carrollton St. 16-23)

## 2-FULL NAME

(a) RESIDENCE NO. 716 N. Carrollton St.

(Usual place of abode)

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 90 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

90 7 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

1928 C. HAMMON JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 28, 1928, to March 13, 1928.

that I last saw him alive on March 13, 1928.

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 13 da.

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Data of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Stansbury M. D.

19 (Address) 1609 Linden Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Green Mount Cem., March 19, 1928  
John C. Mitchell & Sons 1900 Cedar St.

E 31653

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 31653

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 31 Talbot Road St. 15-66 Ward)2-FULL NAME Laurinda Pearl Brewington(a) RESIDENCE NO. 31 Talbot Road St. 15-66 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Walter Brewington6 DATE OF BIRTH (month, day, and year) Dec. 25, 18777 AGE Years 50 Months 2 Days 16 IF LESS than 1 day 1 hrs. 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)10 NAME OF FATHER Harris T. Berry11 BIRTHPLACE OF FATHER (City or town) Md.  
(State or country)12 MAIDEN NAME OF MOTHER Lola13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)14 Informant Ernest W. Brewington  
(Address) 31 Talbot Road15 Filed 1928 C. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 192817 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to March 12, 1928That I last saw her alive on March 12, 1928, and that death occurred, on the date stated above, at 230 Q

The CAUSE OF DEATH\* was as follows:

MyocarditisCONTRIBUTORY (duration) 9 1/2 yrs. 0 mos. 0 ds.  
(Secondary) Myocarditis(duration) 2 1/2 yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) Walter H. H. H. H. M. D.March 12, 1928 (Address) 2220 Garrison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury Md. Date of Burial March 14, 192820 UNDERTAKER John W. Mitchell & Sons ADDRESS 1900 Eutaw St.



E 31654

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31654

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5234 Linden Heights. Arlington.

2-FULL NAME Paul M. Rigney.

(a) RESIDENCE NO. 5234 Linden Heights. Arlington.

(Usual place of abode)

Length of residence in city or town where death occurred

life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

male

4 COLOR OR RACE

white.

5 Single, Married, Widowed, or Divorced, (write the word)

baby

(If married, widowed, or divorced HUSBAND of (or) WIFE of)

DATE OF BIRTH (month, day, and year)

Mar 28, 1928

AGE

Years

1

Months

3

Days

15-16

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant.

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore, City.  
Maryland.

10 NAME OF FATHER

David T. Rigney.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

White Hall,  
Maryland

12 MAIDEN NAME OF MOTHER Hilda B. Rigler.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland.

Informant

(Address)

David T. Rigney (father)  
5234 Linden Heights.

Filed

19

GAMSON JONES, R. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 13, 1928, to Mar 14, 1928.

that I last saw him live on Mar 13, 1928

and that death occurred, on the date stated above, at 2:00 am

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

3/14/28 (Address) 2020 N. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hiseberg Bldg Co. Md.

DATE OF BURIAL

3/15/28

20 UNDERTAKER

J. Walter Davis 177 Paine St.

E 31655

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31655

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 E Fort Ave

ST. 24-35 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Thomas Taylor

## (a) RESIDENCE NO.

1410 E Fort Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

33 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Rose Taylor

## 6 DATE OF BIRTH (month, day, and year)

Oct 12 1855

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

72

5

0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

U.S. Army

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

England

## 10 NAME OF FATHER

Samuel Taylor

## 11 BIRTHPLACE OF FATHER (city or town)

England

(State or country)

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

England

## 14

Informant  
(Address)

Mrs Rose Taylor

1410 Fort Ave

## 15

1928

RPH

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) March 10 1928

## 17

I HEREBY CERTIFY, That I attended deceased from  
Feb 11, 1928 to March 11, 1928.

that I last saw him alive on

March 11, 1928

and that death occurred, on the date stated above, at

2:50 p. m.

The CAUSE OF DEATH\* was as follows:

Trauma

(duration) yrs. mos. 7 ds.

CONTRIBUTORY  
(Secondary)

Chronic Intestinal Hepatitis

(duration) yrs. mos. 30 ds.

## 18 Where was disease contracted

if not at place of death?

No

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Micro

(Signed)

Thos S. Stevens

M. D.

213, 1928 (Address)

2878 Harford Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Cathedral Cemetery

Mar 15 1928

## 20 UNDERTAKER

## ADDRESS

Margaret E. Flynn 1420 Highland St

31656

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

78 E 31656

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 718 Cator Ave 20-70 Ward)

Registered No. ....

2-FULL NAME Alice L. Bailey

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 718 Cator Ave St. .... Ward. ....

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Married, Widowed, or Divorced, (Write the word.)5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Bailey6-DATE OF BIRTH (month, day and year) Aug 1, 18957-AGE 32 yrs. 7 mos. 13 ds. If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer).  
(c) Name of employer.9-BIRTHPLACE (city or town). Bandy Hook (State or Country). Maryland10-NAME OF FATHER Frederick Woodsum11-BIRTHPLACE OF FATHER (city or town). Maine (State or Country).12-MAIDEN NAME OF MOTHER. Lottie Norris13-BIRTHPLACE OF MOTHER (city or town). Mt Savage Md (State or Country).14- (Informant). Mrs. Lottie Woodsum (Address). 718 Cator Ave15- (Signature) RPH

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/13/192817- I HEREBY CERTIFY, That I attended deceased from May 1927 to Mar 12 1928that I last saw him alive on Mar 12 1928and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH\* was as follows:

Epilepsy

## CONTRIBUTORY (Secondary)

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of.Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. H. Bookman M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Landon Park Cemetery DATE OF BURIAL. March 15, 192820-UNDERTAKER, Mary M. Wiedefeld ADDRESS 501 E 22nd St

1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31657

E 31657

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520. W. Fairmount St.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

12 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Annie B. Gray

6 DATE OF BIRTH (month, day, and year)

Aug. 4 - 1893

7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or .... min.

34

7

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Lawrence S. C.

10 NAME OF FATHER

Alexander Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country)

S. C.

12 MAIDEN NAME OF MOTHER

Della Cheek

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

S. C.

14

Informant (Address)

Annie B. Gray 1520. W. Fairmount St.

15

15 1928

H. J. JOHNS, K. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 19 28

17

I HEREBY CERTIFY, That I attended deceased from March 10th, 19 28 to March 12th, 19 28, that I last saw him alive on March 12, 19 28 and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH\* was as follows:

Acct. Parenchymatous Nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinalysis

(Signed)

Walter J. Jackson, M. D.

(Address) 1631 W. Franklin St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

M. J. Fulburn

Mar 15 19 28

20 UNDERTAKER

ADDRESS

Wm. H. Chase &amp; Son

1400 N. Market



E 31658 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31658

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Sinai Hospital 13-59 ST. WARD)

## 2-FULL NAME

Miss Esther Handen Handen

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2020 Whittier Ave ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

10-19-1894

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

33

4

24

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore

10 NAME OF FATHER

Hess Handen

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Jennie Davis

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Russia

Informant  
(Address)Jennie Handen  
2020 Whittier Ave

Filed

15 1928

HARRY R. RICH, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/14 1928

17

I HEREBY CERTIFY, That I attended deceased from

3/13 1928, to

3/14 1928,

that I last saw her alive on

3/14 1928

and that death occurred, on the date stated above, at

7:50 P M

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Cerebral failure

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Henry Ginsburg

M. D.

3/14 1928

(Address) Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Heavenly Friendship Co

3/16 1928

20 UNDERTAKER

ADDRESS

Jack Lewis 1489 E. Pratt St

E 31659

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.,

WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

28 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

7

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Hyman Kaplan

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

54

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town),  
(State or country)

Russia

10 NAME OF FATHER

Harry Linal

11 BIRTHPLACE OF FATHER (city or town),  
(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Chimel

13 BIRTHPLACE OF MOTHER (city or town),  
(State or country)

Russia

Informant  
(Address)Jack Lewis  
1439 E. Balt St

Filed

1928

J. P. J. H. S. H.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 14 1928

17

I HEREBY CERTIFY, that I attended deceased from  
March 13 1928 to March 14 1928.

that I last saw him alive on March 14 1928

and that death occurred, on the date stated above, at 2 P m

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY  
(Secondary)

Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) M. D.

3/14/28 (Address) Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Hehren Rosedale

DATE OF BURIAL

3/15/28

20 UNDERTAKER

Jack Lewis 1439 E. Balt St

E 31660

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31660

1-PLACE OF DEATH

Suai Hospital

CITY OF BALTIMORE: (No. ....)

ST. 3-4 WARD

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Irene Gambel

(a) RESIDENCE NO.

1622 E. Lombard

(Usual place of abode)

ST. .... WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Aug 22 - 1927

AGE

Years

Months

Days

If LESS than

1 day, hrs

or min

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Isaac Gambel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Rosie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

Informant (Address)

Isaac Gambel 1622 E Lombard St

Filed

1928

19

RMYL

Register

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/14 1928

17

I HEREBY CERTIFY, That I attended deceased from

3/10 1928 to 3/14 1928

that I last saw him alive on

3/14 1928

and that death occurred, on the date stated above, at

4.40 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(duration)

yrs.

mos.

4 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Ahren Rosedale

3/15 1928

Jack Lewis 1439 E Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31661

## CERTIFICATE OF DEATH.

101-001  
E 31661

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 561 Orchard St., 17 Ward)2-FULL NAME Harrietta Spicer(a) RESIDENCE NO. 561 Orchard St. 17 Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)Female NegroSingle6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1896

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.3277

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Housework

## 9 BIRTHPLACE (city or town)

(State or country)

NC

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

Dea. Knew

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Dea. Knew

14

Informant  
(Address)Alfred Murray  
724 N. Saratoga

15

Filed

19 1928 C. H. J. Jones R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

March 18 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 18, 1928, to March 13, 1928,that I last saw her alive on March 13, 1928,and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH\* was as follows:

Relapsed Lobar Pneumonia(duration) yrs. mos. 5 ds.CONTRIBUTORY Acute Bronchitis

(Secondary)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/18, 1928

(Address)

J. McRae, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR Date of Burial

St. Luke's Cemetery 3/18/28

20 BERTAKER

ADDRESS

Samuel H. Hensley M. Biddle



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31662

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *844 W. Lexington* 18-16 WARD)2-FULL NAME *Baby Alcorn*(a) RESIDENCE NO. *844 W. Lexington* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, 7 hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

March 10, 1928, to March 11, 1928,

that I last saw him alive on March 10, 1928,

and that death occurred, on the date stated above, at 7.4 m

The CAUSE OF DEATH\* was as follows:

Premature birth 6 1/2 months

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31663

## CERTIFICATE OF DEATH.

E 31663

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 Hemmen

## 2. FULL NAME

Harry E. Lewis

(a) RESIDENCE NO. 2231 Hemmen

(Usual place of abode)

Length of residence in city or town where death occurred

47 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lula M. Lewis

6 DATE OF BIRTH (month, day, and year)

March 25, 1981

7 AGE 47

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employee)

(c) Name of employer

Pack + Co

9 BIRTHPLACE (city or town) (State or country)

Belt

10 NAME OF FATHER

Charles Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

M. Maelstrom

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Lula M. Lewis 2231 Hemmen

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 12, 1928

17

I HEREBY CERTIFY That I attended deceased from

Feb 12, 1928, to May 12, 1928,

that I last saw him alive on May 12, 1928,

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Hesser, M. D.

1928 (Address) 1301 N. Val Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore County

May 12, 1928

20 UNDERTAKER

ADDRESS

George L. Reith 1725 Maryland Ave

E 31664

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44E 31664

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Harford av ST. 9-46 WARD)2-FULL NAME Marian. A. Johnston(a) RESIDENCE NO. 2102 Harford av ST. 9-46 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Wyndom Johnston6 DATE OF BIRTH (month, day, and year) May 5/18557 AGE Years 72 Months 10 Days 7 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER August Kilgus11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.12 MAIDEN NAME OF MOTHER Marian Kilgus13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore14 Informant Joseph Maguire (Address) 2162 Harford av15 16 1928 File Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 192817 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1928, to March 12, 1928, and that I last saw her alive on March 12, 1928, and that death occurred, on the date stated above, at 8:40 P. M. The CAUSE OF DEATH\* was as follows:Carcinoma of Stomach (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? YesDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Yes(Signed) C. K. Shilling, M. D.3/13, 1928 (Address) 1120 St. Paul

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore CountyMarch 15, 1928

20 UNDERTAKER

ADDRESS

George F. Pugh 1735 Harford av

E 31665

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31665

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 250 Pearl St. 4-25 Ward) <sup>170</sup>

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Scurito(a) RESIDENCE NO. 250 Pearl St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Scurito6 DATE OF BIRTH (month, day, and year) Dec 18747 AGE Years 53 Months 3 Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer): \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_

(State or country) Italy10 NAME OF FATHER Anthony Scurito11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Italy12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_14 Informant Margaret Demaree  
(Address) 1718 E. Lombard St.15 Filed 5-19-28 W. J. Jones Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an \_\_\_\_\_  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said \_\_\_\_\_  
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Revolver wound of head  
Suicide (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY  
(Secondary) \_\_\_\_\_(Signed) W. J. Jones M. D.  
(Coroner)15, 1928 (Address) 12739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence: \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Vincent County March 16 1928  
20 UNDERTAKER George J. Rietz ADDRESS 1735 Harford Ave



E 31666 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31666

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Durham ST. 2-4 WARD)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Wright(a) RESIDENCE NO. 319 S. Durham ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced HUSBAND of (or) WIFE of Laura WrightDATE OF BIRTH (month, day, and year) 1877AGE 50 Years Months Days If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker(b) General nature of industry, business, or establishment in which employed (or employer) Mary Burt Co(c) Name of employer Standard Smelting WorksBIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) UnknownInformant (Address) Laura WrightFiled \_\_\_\_\_, 1928

19

J. E. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14 1928

17

I HEREBY CERTIFY, That I attended deceased from

3-8, 1928, to 3-14, 1928that I last saw him alive on 3-13, 1928and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) Influenza(duration) yrs. mos. ds. 8(duration) yrs. mos. ds. 28

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Jones, M. D.3-14-1928 (Address) 2017 E. 32

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Asbury CemeteryDATE OF BURIAL March 1820 UNDERTAKER Edward BryanADDRESS 16 Orleans St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31667

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 W. Lafayette Ave. ST. 16-22 WARD)

REGISTERED NO. 31667

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Lula Wheatley

(a) RESIDENCE No. 1829 W. Lafayette Ave. ST. 16-22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward W. Wheatley

6 DATE OF BIRTH (month, day, and year) August 22, 1864

7 AGE

63 Years

Months 6

Days 20

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Maryland (State or country)

10 NAME OF FATHER Conrad Moeller

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Maryland (State or country)

Informant Mr. Edward W. Wheatley (Address) 1829 W. Lafayette Ave.

Filed

1928

HAROLD JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13 1928

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1927, to March 12, 1928, that I last saw her alive on March 12, 1928, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral lesion of heart

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 24/27, 1927

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

3/13/28 (Address) 1829 W. Lafayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

DATE OF BURIAL

Mar. 15 1928

ADDRESS

1003 West Baltimore St

E 31668 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

118 E 31668  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital 6-37* WARD)2-FULL NAME *Joseph Hawley* (OR HOLLEY)(a) RESIDENCE NO. *Balti City Hospital* ST., WARD(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if not foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *m* 4 COLOR OR RACE *Col.* 5 Single, Married, Widowed, or Divorced, (write the word) *- ?*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE *70 ?* Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER *Don't know*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *md*12 MAIDEN NAME OF MOTHER *Carley*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Don't know*Informant  
(Address)

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-13* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *Jan 1, 1928* to *3-13, 1928*  
that I last saw him alive on *3-13, 1928*and that death occurred, on the date stated above, at *6 PM* m.

The CAUSE OF DEATH was as follows:

*Generalized arteriosclerosis  
Cerebral Myocarditis.*CONTRIBUTORY  
(Secondary)*Submanus*  
*Cerebral Pneumonia*  
(duration) yrs. mos. ds. *2*18 Where was disease contracted  
if not at place of death? *State*Did an operation precede death? *yes* Date of *Jan 7, 1928*Was there an autopsy? *yes*What test confirmed diagnosis? *Physical Signs*(Signed) *Dr. J. M. D.*, 19 (Address) *Balti City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
BURYAL*W. M. C. Cemetery*

UNDERTAKER

*Daniel Coster*

DATE OF BURIAL

*3/15* 19 *28*

ADDRESS

*916*

E 31669

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74001

E 31669

1-PLACE OF DEATH

Home for Invalids

CITY OF BALTIMORE: (No. 40

114 Cedar Ave.

ST.

13-49

WARD)

2-FULL NAME

Mrs. Georgianna Burns

(a) RESIDENCE NO.

Home for Invalids

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

Robert E. Burns

DATE OF BIRTH (month, day, and year)

1844 - Jan. 21.

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 22

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Maryland -

10 NAME OF FATHER

Samuel Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

Informant (Address)

Howard L. Burns 1114 W. Cross St.

Filed

MAR 15 1928

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 14 1928

17

I HEREBY CERTIFY, that I attended deceased from March 3, 1928, to March 13, 1928.

that I last saw ~~her~~ alive on March 13, 1928

and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical Exam.

(Signed)

W. B. Mayo, M. D.

3/14, 1928 (Address)

Medical Arts Building

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Larkwood Cem.

Mar. 16 1928.

UNDERTAKER

ADDRESS

Mrs. John W. Diefel & Son 801 W. Fayette St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31670

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1511 North Broadway

CITY OF BALTIMORE: (No 1511 North Broadway ST.: 8 WARD)

2-FULL NAME Percy Lambert Sappington

(a) RESIDENCE. No. 1511 North Broadway ST. 8 WARD.  
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Divorced

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1877

7 AGE Years 50 Months 3 Days 23 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Casket Manufacturing

(c) Name of employer Eastern Casket Co.

BIRTHPLACE (city or town). Baltimore, Md.  
(State or country)

10 NAME OF FATHER Wm L. Sappington

11 BIRTHPLACE OF FATHER (city or town).  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabella Simpson

13 BIRTHPLACE OF MOTHER (city or town).  
(State or country) Baltimore, Md.Informant Wm L. Sappington (Father)  
(Address) 1511 N. Broadway

Filed 1928, 19 C. HARRISON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to March 12, 1928, that I last saw him alive on March 12, 1928, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH\* was as follows:

Hemorrhage from gastric ulcer

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gastric ulcer Probably (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special tests

(Signed) Chas. McDonald, M. D.

19, 1928 (Address) 1540 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery 3/15/1928

20 UNDERTAKER ADDRESS

Philip Herwig 2016 Orleans St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31671

## CERTIFICATE OF DEATH.

E 31671

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 Ashland Ave ST. 7-13 WARD)2-FULL NAME Catherine Siebert

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1633 Ashland Ave ST. 7-13 WARDLength of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Divorced

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 27/63AGE Years 64 Months 5 Days 15 If LESS than day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto10 NAME OF FATHER John Ruppert11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.12 MAIDEN NAME OF MOTHER Barbara13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.Informant (Address) Matilda C. Scarborough

Filed

1928

C. HARRISON JONES, JR.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/28

17

HEREBY CERTIFY, That I attended deceased from March 12, 1928 to March 13, 1928that I last saw him alive on March 12, 1928 and that death occurred, on the date stated above, at 8:40 m.

The CAUSE OF DEATH\* was as follows:

Facial Erysipelas(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signature)

J. W. Storer M. D. (Address) 1404 C. Eayre St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Baltimore

DATE OF BURIAL

3/15/28

20 UNDERTAKER

ADDRESS

Philip Herwig 2016 Orleans

E 31672

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

162 E 31672

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 867 W. Franklin St. 18-76 Ward)

2-FULL NAME Minna E. Gibson

(a) RESIDENCE NO. 867 W. Franklin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND or  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 Filed

1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-topsy or inquiry.) and that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Congenital  
Anemia  
(duration) .....yrs. ....mos. ....ds.CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) M. D.

(Coroner)

3/15, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL

M. Auburn Ave

3-15-1928

UNDERTAKER

ADDRESS 916

Naim Carter

Be an

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31673

## CERTIFICATE OF DEATH.

E 31673

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 412 Argyle Ave St., 4-20 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 412 Argyle Ave

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

Col.

5 Single, Married, Widowed, or Divorced. (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 1908

7 AGE

Years

20

Months

1

Days

15

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

maid 70

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto

(State or country)

Md.

10 NAME OF FATHER

John H. Holly

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Isabella Young

13 BIRTHPLACE OF MOTHER (city or town)

Balto City

(State or country)

14

Informant (Address)

Isabella Holly 412 Argyle Ave

15 Filed..... 19

15 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

3/13/1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 17, 1928, to Mar 13, 28

that I last saw him alive on Mar 12, 1928

and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH\* was as follows:

Auto Intoxication

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed)

John H. Holly, M. D.

, 19

(Address)

412 Argyle Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Ashbury Cemetery

3/15/28

20 UNDERTAKER

ADDRESS

Mrs. R. G. Elliott

1725 Ashland Ave



31674

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed,  
or Divorced, (write the word)If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

12-26-27

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

2

18

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

Major Spriggs

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Bertha Sharp

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

Informant

(Address)

Recnas -

Filed

1928

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

38 E 31674

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 14 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 1, 1928, to Mar. 17, 1928.

that I last saw him alive on Mar. 14, 1928,  
and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH\* was as follows:

Congenital Syphilis

(duration)

yrs. 2

mos. 14

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

at home?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

Wassermann

(Signed)

J. B. Bennett

M. D.

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

M. W. G. Ellert

1725

Arlington

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31675

## CERTIFICATE OF DEATH.

129 E 31675  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *West Balto General Hospital*)2-FULL NAME *William Nicholson*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *3713 Edmondson ST.*

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. *1* mos. *29* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Haggie P. Nicholson*DATE OF BIRTH (month, day, and year) *Jan 15 - 1868*AGE Years *60* Months *1* Days *29* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Police Sgt.*BIRTHPLACE (city or town) (State or country) *Balto, Md.*10 NAME OF FATHER *Henry Nicholson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto, Md.*12 MAIDEN NAME OF MOTHER *Marriett Tucker*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Virginia*Informant *Haggie P. Nicholson*  
(Address) *3713 Edmondson St.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 14 1928*17 I HEREBY CERTIFY, That I attended deceased from *Oct. 21, 1927* to *March 14, 1928*that I last saw him live on *March 14, 1928* and that death occurred, on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*

CONTRIBUTORY (Secondary)

(duration) yrs. *4* mos. ds.(duration) ? yrs. *10* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clin. Exam*(Signed) *Louis T. Ravy*, M. D.  
3/14, 1928 (Address) *W. Balto Gen Hosp*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Loudon Park*

DATE OF BURIAL

20 UNDERTAKER *See Will*

ADDRESS

Filed *5-1928*

G. H. JONES, K. D. Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31676

## CERTIFICATE OF DEATH.

E 31676

1-PLACE OF DEATH

Bm Secours Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Grace Le Fevre

(a) RESIDENCE NO.

715 Linwood St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Ralph R. Le Fevre

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Littlestown Pa

12 MAIDEN NAME OF MOTHER

Josephine Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

Informant (Address)

Ralph R. Le Fevre 715 Linwood St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15- 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 14, 1928, to Mar 15- 1928,

that I last saw him alive on Mar 15- 1928,

and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH\* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dudley P. Brown, M. D.

3/15, 1928 (Address) 904 N. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 15 1928

Registrar

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 31677

E 31677

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2704 Chelsea Ter St. 15-65 Ward)2-FULL NAME Baby Martin(a) RESIDENCE NO. 2704 Chelsea Terrace

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred yrs. mos. / ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhite

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year)

2/13/28

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

10 NAME OF FATHER

Wm. F. Martin

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Stewartstown - Pa.

12 MAIDEN NAME OF MOTHER

E. L. Spickard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant (Address)

Wm. F. Martin

15 Filed

5 1928

C. HAMMON JONES, R. D.

Per

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28March 14

17

I HEREBY CERTIFY, That I attended deceased from

March 13, 1928, to March 14, 1928.that I last saw him alive on March 14, 1928.and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Epidemic Neorotavirus(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds.

CONTRIBUTORY

(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Physical Exam(Signed) Donald B. Bayne M. D.. 19 (Address) Walton Apt.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Lowell ParkMar 15 1928

20 UNDERTAKER

ADDRESS

W. J. McKinnon SonsNorth Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31678

101E 31678

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *70-69* *5 Gorman Ave* ST. WARD

## 2-FULL NAME

*Elizabeth Katter*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *5 Gorman Ave* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *widow*If married, widowed, or divorced HUSBAND of (or) WIFE of *Henry Katter*DATE OF BIRTH (month, day, and year) *July 20, 1856*AGE Years *71* Months *7* Days *25* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *house work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Balt Md.*10 NAME OF FATHER *Geo - Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*Informant *Mr. Fred H. Katter* (Address) *5 Gorman Ave*1928 *C. HAMMON JONES, R. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 15, 1928*17 I HEREBY CERTIFY, That I attended deceased from *Nov 2, 1928* to *Nov 15, 1928*that I last saw her alive on *Nov 13, 1928*and that death occurred, on the date stated above, at *4 A.* m.

The CAUSE OF DEATH\* was as follows:

*Acute Cordiac Dilatation*CONTRIBUTORY (Secondary) *Myocardial Infarction* (duration) yrs. mos. ds. *13* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physician's only*(Signed) *James H. [Signature]* (M. D.) *2/10/28* Address *1727 [Address]*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Our own grave**Nov 15, 1928*

20 UNDERTAKER

ADDRESS

*John J. Brown & Son**401 [Address]*

E 31679

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31679

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1318 Edmondson Ave.* St. *19-76* Ward)

Registered No. ....

2-FULL NAME *Theresa Magdaline Corron*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *1318 Edmondson Ave.* St. .... Ward .....(Usual place of abode)  
Length of residence in city or town where death occurred *47* yrs. .... mos. .... ds. How long in U. S. if of foreign birth? yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Wh.* 5-If married, widowed, or divorced, HUSBAND of (or) WIFE *Samuel J. Corron*6-DATE OF BIRTH (month, day and year) *April 27, 1880*7-AGE, *47* yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *T.W.*

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) *Baltimore* (State or Country).10-NAME OF FATHER *Phillip Pearson*11-BIRTHPLACE OF FATHER (city or town) *Ireland* (State or Country).12-MAIDEN NAME OF MOTHER, *Mary English*13-BIRTHPLACE OF MOTHER (city or town) *Ireland* (State or Country).1- (Informant) *Maria Corron Wilgar* (Address) *2031 Harlem Ave.*

1928 C. HAMMOND JONES, R. D. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *March 15, 1928*17- I HEREBY CERTIFY, That I attended deceased from *May 30* 1927, to *March 15* 1928 that I last saw her alive on *March 15* 1928and that death occurred, on the date stated above, at *9.25 a.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of uterus*(Duration) *2* yrs. .... mos. .... ds.CONTRIBUTORY *Carcinomatosis* (Secondary)

(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date of .....Was there an autopsy? *No*What test confirmed diagnosis? *Usual signs*(Signed) *Geo. E. Wells* M. D., 19 (Address) *1413 Edmondson Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL *St. Johns Hospital* DATE OF BURIAL *3/16* 192820-UNDERTAKER *Wm. Cook* ADDRESS *502 E. North*

E 31680

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31680

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Memorial Hospital* REGISTERED NO. *111-12-44*  
 CITY OF BALTIMORE: (No. *12-44* ST. *12-44* WARD)  
 2-FULL NAME *Harry A. Cooney*  
 (a) RESIDENCE NO. *Bradford, Pa.* ST., \_\_\_\_\_ WARD \_\_\_\_\_  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred *0* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

If married, widowed, or divorced HUSBAND of (or) WIFE of *Myrna Catherine Cooney*

DATE OF BIRTH (month, day, and year) *Nov 22, 1885*

AGE *42* Years *3* Months *22* Days *23* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Machinist*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Pa.*

10 NAME OF FATHER *Edward H. Cooney*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *N.Y.*

12 MAIDEN NAME OF MOTHER *Mary Quinn*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Scotland*

Informant *Deceased*  
 (Address)

1028

19

*G. HAMMOND JONES, JR.*  
*R.R.N.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-15-1928*

17

I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19*28*, to *March 15, 1928*.

that I last saw him alive on *March 14, 1928*.

and that death occurred, on the date stated above, at *7:14 A* m.

The CAUSE OF DEATH\* was as follows:

*Duodenal ulcer*

(duration) *7* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY

(Secondary)

*Intestinal Obstruction*  
*Fecal fistula* (duration) *4* days \_\_\_\_\_ mos. *23* ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *Yes* Date of \_\_\_\_\_

Was there an autopsy? *No*

What test confirmed diagnosis? *Operation*

(Signed) *J. J. Geraghty* M. D.

, 19 (Address) *Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Clean New York*

20 UNDERTAKER

*Wm Cook*

DATE OF BURIAL

*3/15/28*

ADDRESS

*522 E. Voth*





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31682

## CERTIFICATE OF DEATH.

E 31682

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 23-31 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Siscoe(a) RESIDENCE NO. 122 Walk Lane

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Negro 5 Single, Married, Widowed, or Divorced. (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. About 60

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Unknown(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

## 9 BIRTHPLACE (city or town).....

(State or country) Unknown

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Unknown

## 14

Informant (Address)

Hospital Record

## 15

Eleg.

19

C. HAMPTON JOHNS, R. 8  
R. P. H.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 192 817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Chronic Nephritis with Uremia.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) Eugene J. Hill M. D. (Coroner)3/2, 1928 (Address) 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## 20 UNDERTAKER

ADDRESS

Cecil Astor Health

PARENTS

JOHNS HOPKINS HOSPITAL MAR 14 1928

31683

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31683

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Colonial Hospital* St. *16-22* Ward)

2-FULL NAME

(Residence in Baltimore: No. *Not Known* St.; yrs. .... mos. .... ds.)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>Black</i>	5-Single, Married, Widowed, or Divorced, (Write the word.)	16-DATE OF DEATH, <i>Mar 2</i> (Month) (Day) (Year)	17-I HEREBY CERTIFY That I took charge of the Remains described above, held an Inquest, autopsy or Inquiry, thereon and from the evidence obtained by said Inquest, autopsy or Inquiry, find that said deceased came to death on the day stated above.
6-AGE, <i>23</i> yrs. .... mos. .... ds.			The CAUSE OF DEATH* follows: <i>Pul T. B.</i>	
7-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).			CONTRIBUTORY (Secondary) <i>Mar G C Shades</i> (Signed) <i>Mar G C Shades</i> 192... (Address) <i>316 Bway</i>	
8-BIRTHPLACE, (State or Country), <i>Unknown</i>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
9-NAME OF FATHER,			18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death... yrs. .... mos. .... ds. In the State... yrs. .... mos. .... ds.	
10-BIRTHPLACE OF FATHER, (State or Country),			Where was disease contracted, if not at place of death? Former or usual residence	
11-MAIDEN NAME OF MOTHER,			19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,	
12-BIRTHPLACE OF MOTHER, (State or Country),			20-UNDERTAKER, ADDRESS	
13-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) ..... (Address) .....			JOHN S HOPKINS HOSPITAL Commissioner Health	

1928

C. HAMMOND JONES, R. D.  
Registrar.

2265

THE MORGUE.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31684

## CERTIFICATE OF DEATH.

90 E 31684

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

BALTIMORE CITY HOSPITAL

ST. 18-76 WARD)

2-FULL NAME *Elizabel Taylor*

(a) RESIDENCE NO. *865 Lexington*

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs. mos.

ST. WARD

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *colored* 5 Single, Married, Widowed, or Divorced, (write the word) *?*

If married, widowed, or divorced HUSBAND of (or) WIFE of *?*

DATE OF BIRTH (month, day, and year) *2*

AGE Years Months Days If LESS than 1 day, hrs. or min. *55*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Engineer*

(b) General nature of industry, business, or establishment in which employed (or employer) *030*

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Maryland*

10 NAME OF FATHER *Samuel Taylor*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Mary*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

Informant (Address) *Records*

1928 C. HANCOCK JONES, R. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/28/1928*

17 I HEREBY CERTIFY, That I attended deceased from *Aug. 8, 1927, to Dec. 28, 1928,* that I last saw him live on *Dec. 28, 1928,* and that death occurred, on the date stated above, at *3:00 p. m.*

The CAUSE OF DEATH\* was as follows:

*Swollen pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *myocarditis*

18 Where was disease contracted if not at place of death? *?* yrs. mos. ds.

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *General & Suer*

(Signed) *C. J. Tolson*, M. D. 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL MAR 14 1928

Commissioener Health.

31685

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31685

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hosp. 11-25* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant (Address)

File

5 1928

C. HAMMON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar 13, 1928 to Mar 14, 1928.

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Cranial Hemorrhage due to  
difficult labor

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JNS HOPKINS HOSPITAL

20 UNDERTAKER

ADDRESS

Baltimore Health

MAR 15 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31686

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*CITY OF BALTIMORE: (No. *Lombard & Greene* ST. *16-70* WARD)2-FULL NAME *Charles Nicholas Roberts*(a) RESIDENCE NO. *611 N. Dennison* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced HUSBAND of (or) WIFE of *Marjorie G. Roberts*DATE OF BIRTH (month, day, and year) *May 30, 1891*AGE Years Months Days If LESS than 1 day, hrs. or min. *36* *9* *14* *15*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Wisconsin*10 NAME OF FATHER *Joseph Roberts*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Spooner Wisconsin*12 MAIDEN NAME OF MOTHER *Angeline Marrott*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Spooner Wisconsin*Informant *Mrs. Marjorie G. Roberts* (Address) *611 N. Dennison St.*5-1928 *C. HAMMOND JONES, R. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-14* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *1-26*, 19 *28*, to *3-14*, 19 *28*.that I last saw him alive on *3-14*, 19 *28*.and that death occurred, on the date stated above, at *10 30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Rheumatic cardio-vascular disease; auricular fibrillation*CONTRIBUTORY (duration) *2 weeks* yrs. mos. ds. *Septicemia* (duration) *4 weeks* yrs. mos. ds.18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *clinical & autopsy*(Signed) *Henry Vincent Davis*, M. D.19 (Address) *Univ. Hosp.*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Mt. Airey, Md.*

UNDERTAKER

*Robert Cook*

DATE OF BURIAL

*Mar. 17, 1928*

ADDRESS

*1003 West Baltimore St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31687

E 31687

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp—ST. 17-25 WARD)2-FULL NAME Poist, W.M.(a) RESIDENCE NO. 637 Franklin (West)

(Usual place of abode)

WARD

Length of residence in city or town where death occurred Life mos. ds.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

maleWhiteMarriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Annie PoistDATE OF BIRTH (month, day, and year) Oct. 15, 1852

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.75430

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland10 NAME OF FATHER Jerome Poist11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Eliz. Cole13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) MarylandInformant  
(Address)Mr. William R. Poist  
790 Columbus Ave. New York

1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
3-11-28, 19 28, to 3-14, 19 28.that I last saw him alive on 3-14-28 19 28and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Prostate(duration) 2 yrs. 3 mos. 7 ds.CONTRIBUTORY  
(Secondary)(duration) 1 yrs. 2 mos. 3 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? yes Date of 3-11-28Was there an autopsy? yesWhat test confirmed diagnosis? yes(Signed) T. H. Thompson, M. D.1/14/1928 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park CemeteryMar. 17 19 28

20 UNDERTAKER

ADDRESS

1003 West  
Baltimore St.

31688

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31688

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2410 Druid Hill Ave*)ST. *13-54* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Rosaria Biondo*(a) RESIDENCE NO. *2410 Druid Hill Ave*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *27* mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*DATE OF BIRTH (month, day, and year) *Sept 12<sup>th</sup> 1877*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*50**6**2*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Italy*

10 NAME OF FATHER

*Joseph Biondo*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Italy*

12 MAIDEN NAME OF MOTHER

*Bonetta Geller*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Italy*

Informant (Address)

*Salvatore Biondo*  
*2410 Druid Hill Ave*

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 14 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 1 1928* to *March 14 1928*, that I last saw her alive on *March 14 1928*, and that death occurred, on the date stated above, at *3 P. m.*

The CAUSE OF DEATH\* was/as follows:

*Chronic Myocarditis*(duration) *several* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical diagnosis*  
(Signed) *Benjamin P. Hershman* M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Holy Redeemer*

20 UNDERTAKER

*Frank V. Pipitone*

DATE OF BURIAL

*March 17<sup>th</sup> 1928*

ADDRESS

*2818 E. Baltimore St*

31689

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31689

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

33rd &amp; Calvert

ST. 27-53 WARD)

2-FULL NAME

Harriet Whiteley Baker

(a) RESIDENCE

No. 4 Somerset Road Baltimore Md

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

If married, widowed, or divorced

HUSBAND or (or) WIFE of

Mr. Charles Baker (d)

DATE OF BIRTH (month, day, and year)

Oct 11, 1860

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

67

4

3

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Ben Whiteley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Stone

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

Informant

(Address)

Mrs. Hand 2 Somerset Road B.P.

Filed

1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1928

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1927, to March 15, 1928.

that I last saw him alive on March 15, 1928.

and that death occurred, on the date stated above, at 10:00 p. m.

The CAUSE OF DEATH\* was as follows:

Sarcoma of Pleura.

(duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4 Somerset Road

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? x-ray - Physical Signs

(Signed) M. D.

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cem March 17 1928

UNDERTAKER

ADDRESS

Henry W. Jenkins 1000 M. College



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31690

## CERTIFICATE OF DEATH.

143 E 31690

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 1-2 Ward)2-FULL NAME I R E N E B R O W N I N G(a) RESIDENCE NO. 513 S. Ellwood Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of William F. Browning Jr.  
(or) WIFE of6 DATE OF BIRTH (month, day, and year)  
April 6, 19097 AGE Years 18 Months 11 Days 8 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER Frederick Bellman11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Maggie Smith13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)14 Informant William F. Browning Jr. (Husband)  
(Address) 513 S. Ellwood Ave.15 Filed C. HARRISON JONES, R. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said InquestInquest find that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH was as follows:  
Self Induced Abortion  
about 11 weeksCONTRIBUTORY Septicemia  
(duration) yrs. mos. ds. 9Mar 14 1928 G. C. Glader  
(Signature) (duration) yrs. mos. ds. 5  
(Address) 143 16th May

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Olivet CemeteryDate of Burial Mar. 17 1928

20 UNDERTAKER

Henry Sander & Sons Inc.Baltimore St. & BROADWAY

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31691

E 31691

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST. \_\_\_\_\_ WARD)

2-FULL NAME

Virginia Papp

(a) RESIDENCE NO.

Linden Ave, Arbutus Md. 20th

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

17 yrs.

4 mos.

29 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Oct 21st 1910

AGE

Years

Months

Days

If LESS than  
1 day, ... hrs.  
or ... min.

17

4

29

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Md.

10 NAME OF FATHER

Joseph Papp

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant  
(Address)

Joseph Papp

5 1928

HARRISON JONES, R. U.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-14

1928

17

I HEREBY CERTIFY, That I attended deceased from

3-11, 1928, to 3-14, 1928,

that I last saw her alive on 3-14, 1928

and that death occurred, on the date stated above, at 12<sup>50</sup> a. m.

The CAUSE OF DEATH\* was as follows:

Cerebro-Spinal Meningitis  
Staphylococcus aureus (Non Epidemic)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Spinal puncture

(Signed) Francis L. Sweeney, M. D.

19 (Address) St. Agnes' Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Linden Ave Arbutus Md

Mar 16 1928

FUNERAL

ADDRESS

H. W. Wipperfurth, 1850 W. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31692

31692

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 247 S. Castle ST. 6-9 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 247 S. Castle ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds.

72 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Widowed  
HUSBAND of Margaret A. Hagan  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

89 9 10

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

1928

19

C. HAMPTON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1928

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1927, to March 14, 1928, that I last saw him alive on March 14, 1928, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

myocarditis (chronic)

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

3.10.28

(Address)

514 Quincy Lane

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

J. A. Moran

E. Ballak

E 31693 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

90 E 31693

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 22-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Cohen(a) RESIDENCE NO. 107 Welcome Alley WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of ?

DATE OF BIRTH (month, day, and year) ?

AGE Years 43 Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Georgia10 NAME OF FATHER Benjamin Cohen11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia12 MAIDEN NAME OF MOTHER Betty13 BIRTHPLACE OF MOTHER (city or town) (State or country) GeorgiaInformant (Address) Reginald

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 10, 1928 to Mar. 12, 1928that I last saw him alive on Mar. 12, 1928and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic + acute  
arteriosclerosis(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General + Sub.(Signed) C. J. Holmes Boyd M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Zion at Mt. 16 1928  
UNDERTAKER W. H. Brown Sen. W. Montgomery  
ADDRESS 108

Filed 16 1928

Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31694

1-PLACE OF DEATH

City of BALTIMORE: (No. *4900 Eastern St.* Ward *18-76*)2-FULL NAME *Joseph S. Page*(a) RESIDENCE NO. *7 E. W. Harlan* Ward *18-76*

(Usual place of abode)

Length of residence in city or town where death occurred *12 yrs.* ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 Color or Race *C*5 ~~Single~~ Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Rebecca Page*6 DATE OF BIRTH (month, day, and year) *Apr 8 1888*7 AGE *39* YearsMonths *11*Days *5*

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED *Labors*

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *VA*

(State or country)

10 NAME OF FATHER *Ed. Page*11 BIRTHPLACE OF FATHER (city or town) *VA*

(State or country)

12 MAIDEN NAME OF MOTHER *Caroline Boels*13 BIRTHPLACE OF MOTHER (city or town) *VA*

(State or country)

Informant *Alfred Madison*(Address) *177 Maryland*

16 1928

Filed *1928*

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90  
REGISTERED NO.

E 31694

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 3 1928*17 I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* and that said deceased came to *his* death on the day stated above.The CAUSE OF DEATH was as follows: *Heart Stenosis*CONTRIBUTORY (Secondary) *Coronary*(duration) yrs. mos. ds. *Mar 3 1928*(Address) *4316 1/2 Wray*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Providence* Date of Burial *3/17 1928*20 UNDERTAKER *Byron Wright* ADDRESS *1218*

E 31695

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

188-001  
E 31695  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *May 10 P.* S. *12-51* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *26 39 Oak*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos. ds.

St. Ward

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)*Male**White**Married*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Blanch Bradford*

6 DATE OF BIRTH (month, day, and year)

*Jan 21, 1867*

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

*61**1**23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

*Watchman  
(tender)*

9 BIRTHPLACE (city or town)

(State or country)

*Ind*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)*Blanch R. Bradford  
26 39 Oak St.*

15 DIED

16 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 14 1928* 19217 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an *inquest*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

*inquest* and that said deceased came to *his death*

topsy or inquiry,

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Internal injury  
prob. heart small  
Internal injuries  
(duration) yrs. mos. ds. (docs)*CONTRIBUTORY  
(Secondary)*Gun wound  
(duration) yrs. mos. ds.**Rich* (Signed) *Rich* M. D.19 Address *16 57 2nd*\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place *Gun house* In the  
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL*Park Road Gen. Burial 15 1928*

20 UNDERTAKER

*Chenoweth & Son* ADDRESS *36 1st*  
*Chestnut*

E 31696

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

St. Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 2-4 WARD)

2. FULL NAME

Mrs. Mary Newburger

(a) RESIDENCE No.

2011 E. Lombard ST. 6

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

69 yrs. 7 mos. 21 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

widow

If married, widowed, or divorced

HUSBAND of (or) WIFE of

Martin M. Newburger

not given

DATE OF BIRTH (month, day, and year)

July 22, 1858

AGE

Years

Months

Days 22

If LESS than 1 day, hrs. or min.

69

7

21

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

not given Balto. Md.

10 NAME OF FATHER

Andrew S. Ruben

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

"

"

12 MAIDEN NAME OF MOTHER

Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

"

"

Informant

(Address)

Son - Mr. Newburger  
427 N. Rose St.

Filed

AR 16 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14 1928

17

I HEREBY CERTIFY, That I attended deceased from

3-12 1928, to 3-14 1928.

that I last saw her alive on 3-14 1928

and that death occurred, on the date stated above, at 1-2 m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia.

CONTRIBUTORY (duration) yrs. mos. 10 ds.  
Chc. Interstitial -  
(Secondary) Hepatitis (duration) ? yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. L. D'Adda Liacca M. D.

, 19

(Address)

St. Agnes Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

Mar 17 1928

UNDERTAKER

ADDRESS

Lilly + Ziehl Inc.

4035 W. 1st St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31697

## CERTIFICATE OF DEATH

100-001

E 31697

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 308. S. Wolfe St. St. 2<sup>nd</sup> Ward)2-FULL NAME Mary C. Baker(a) RESIDENCE NO. 388 S. Wolfe St. St. 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 5 mos.   ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of William W. Baker6 DATE OF BIRTH (month, day, and year) October 18607 AGE Years 67 Months 5 Days   IF LESS than 1 day...hrs. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Balto Md10 NAME OF FATHER Henz Rose11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto Md.12 MAIDEN NAME OF MOTHER May Shanahan13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.14 Informant William W. Baker (Address) 308 S. Wolfe St15 Filed 16 1928 Registrar [Signature]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1928 19 2817 I HEREBY CERTIFY, That I attended deceased from March 13, 1928, to March 14, 1928.that I last saw her alive on March 13, 1928.and that death occurred, on the date stated above, at 8:10 A. M.

The CAUSE OF DEATH\* was as follows:

Brachial Pneumonia(duration) yrs. mos. 7 da.CONTRIBUTORY (Secondary) Arterio-sclerosis(duration) yrs. 7 mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) N. J. Davidson, M. D., 19 (Address) 3035 Edmond St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt. Carmel Cont. March 17, 1928

20 UNDERTAKER

ADDRESS

Lilly & Zeiber Inc 403 S. Wolfe



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31698

## CERTIFICATE OF DEATH.

31 E 31698

### 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *3647 Chestnut Ave* ST. *13-52* WARD)

### 2-FULL NAME

(a) RESIDENCE NO. *3647 Chestnut Ave* ST. *13-52* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

If married, widowed, or divorced

HUSBAND or (or) WIFE of *Norris D Poole*

DATE OF BIRTH (month, day, and year) *Feb 22-1905*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*23*

*23*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town, State or country)

*Balto. City*

10 NAME OF FATHER

*Charles Wiener*

11 BIRTHPLACE OF FATHER (city or town, State or country)

*Balto. Co.*

12 MAIDEN NAME OF MOTHER

*Lida Whitmore*

13 BIRTHPLACE OF MOTHER (city or town, State or country)

*Balto. Co.*

Informant

(Address)

*Mrs. Lida Wiener 3647 Chestnut Ave*

Filed

*18 1928*

*C. HAYDON JONES, R.*

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 15<sup>th</sup> 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*December 3, 1927, to March 14<sup>th</sup> 1928*

that I last saw her alive on *March 14<sup>th</sup> 1928*

and that death occurred, on the date stated above, at *12:45* A. M.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

*Unknown*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *At place of death*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Personal observation*

(Signed) *Mr. Conrad Bode*, M. D.

, 19 (Address) *1900 Maryland Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Mt Zion Balto Co Mar 18 1928*

UNDERTAKER

ADDRESS

*A S Marshall 3539 Fall Road*

## E 31699 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 31699

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 W Pratt ST. 19-28 WARD)

2. FULL NAME *The Haurakian*(a) RESIDENCE NO. *1312 W Pratt*

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. mos. ds.ST. *19* WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 22-1870*7 AGE Years Months Days *57 5 20* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. *Shoe Cutter*(b) General nature of industry, business, or establishment in which employed (or employer) *Mr. Moushau*

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) *Barto and*9 NAME OF FATHER *Michael*10 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*11 MAIDEN NAME OF MOTHER *Ann Cullen*12 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*13 Informant (Address) *Katherine Hamsley 1312 W Pratt St*Filed *16 1928*Registrar *W. B. ...*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/14/28*

17

I HEREBY CERTIFY, That I attended deceased from *2/27/28* 19 to *3/14/28* 19that I last saw him alive on *3/4/28* 19and that death occurred, on the date stated above, at *7 p.m.*

The CAUSE OF DEATH\* was as follows:

*urthemia*(duration) yrs. mos. ds. *5*

CONTRIBUTORY (Secondary)

(duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Specimen*(Signed) *F. M. ...*(Address) *3755 ...*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*New Cathedral 3-17-1928 1136 Popple St*

## E 31700 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31700

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Thomas Ave., ST. 15-68 WARD)

2-FULL NAME Malachy Lyons

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

(a) RESIDENCE NO. 1714 Thomas Ave., ST. \_\_\_\_\_ WARD \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed,  
 or Divorced, (write the word) Married

If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

Mary T. Lyons

DATE OF BIRTH (month, day, and year) June ? 1862

AGE 65 Years 9 Months Days If LESS than  
 1 day, hrs.  
 or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
 particular kind of work Laborer

(b) General nature of industry,  
 business, or establishment in  
 which employed (or employer) City

(c) Name of employer

BIRTHPLACE (city or town) Ireland  
 (State or country) (County Roscommon)

10 NAME OF FATHER Malachy Lyons

11 BIRTHPLACE OF FATHER (city or town)  
 (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
 (State or country) Ireland

Informant Mrs. Mary T. Lyons.  
 (Address) 1714 Thomas Ave.

Filed 19 \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1928

17

I HEREBY CERTIFY, That I attended deceased from  
 January 17th 28 to March 13th 19 28.

that I last saw him alive on March 13th 19 28.

and that death occurred, on the date stated above, at 10:45 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Oesophagus

(duration) yrs. 2 mos. +

CONTRIBUTORY Acidosis  
 (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted  
 if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) *Edw. Revolutian* M. D.

3/15, 1928 (Address) 24 N. Fulton Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-  
 MOVAL

New Cathedral

DATE OF BURIAL

3-17-1928

20 UNDERTAKER

ADDRESS

H. Branning 500 N. 1136. Polesong St

E 31701

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

89 E 31701

## PLACE OF DEATH

CITY OF BALTIMORE (No.

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.) Married

## 6-DATE OF BIRTH,

May

4

1868

(Month)

(Day)

(Year)

## 7-AGE,

59

10

10

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Retired  
B+O.R.R.9-BIRTHPLACE,  
(State or Country),

England

## 10-NAME OF FATHER,

William C Holland

11-BIRTHPLACE OF FATHER  
(State or Country),

England

## 12-MAIDEN NAME OF MOTHER

Hannah M. Bennett

13-BIRTHPLACE OF MOTHER  
(State or Country),

England

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Marie Holland

(Address)

24 Gorman Ave

## 15-

16 1928

HARRISON JONES, K. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 14

1928

(Month)

(Day)

(Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Malignant Pyrexia

CONTRIBUTORY  
(Secondary)

Mar 14 1928

1578

191 (Address) 1437 13 May

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Western Cemetery March 17, 1928

## 20-UNDERTAKER ADDRESS

Josiah Syber 1600 W. Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31702

## CERTIFICATE OF DEATH.

73 E 31702

1-PLACE OF DEATH 3

CITY OF BALTIMORE: (No. 325 Oakland Ave. 27-48

2-FULL NAME John Graf Jr.

(a) RESIDENCE No. 525 Oakland Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 19 ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1924.

7 AGE 4

Years

Months 0

Days 19

20 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md.

10 NAME OF FATHER John Graf

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.

12 MAIDEN NAME OF MOTHER William May Townsend

13 BIRTHPLACE OF MOTHER (city or town) Virginia

Informant John Graf Jr.

(Address) 525 Oakland Ave.

Filed

19

J. H. JONES, R. J.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1928

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1927, to March 14, 1928, that I last saw him alive on March 14, 1928,

and that death occurred, on the date stated above, at 7:20 P. M.

The CAUSE OF DEATH\* was as follows:

Bulbar Palsy.

CONTRIBUTORY (Secondary)

(duration)

1 yrs. 3 mos. ds.

(duration)

yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel B. Walk

M. D.

19

(Address) 1331 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Harold Ridge

March 17 1928

Jasiah Lyfex 1600 W. North Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31703

## CERTIFICATE OF DEATH.

101-901  
E 31703  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Reynolds.

ST

WARD

## 2-FULL NAME

Francis Richard Wilhelm

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1417 Reynolds

ST,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

male

white

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

February 16 1928

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Infant

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md.

10 NAME OF FATHER

Frank Wilhelm

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Helen Singulecki

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore Md.

14

Informant  
(Address)Helen Singulecki  
1417 Reynolds

MAR 16 1928

BALTIMORE, MD.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 13, 1928, to Mar. 15, 1928.

that I last saw him alive on

Mar. 14, 1928

and that death occurred, on the date stated above, at

50 m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

No

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

How

(Signed)

Chas. H. Stewins, M. D.

3/15, 1928 (Address)

2875 Halford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Cedar Hill.

DATE OF BURIAL

Mar 16 1928

20 UNDERTAKER

Chas. H. Stewins

ADDRESS

1501  
E. Fort. E.

31704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31704

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3322 Hudson*)

ST., *1-1* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George A. Downing*

(a) RESIDENCE NO. *3322 Hudson*

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos.

How long in U. S., if of foreign birth? *40* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

If married, widowed, or divorced

HUSBAND of *Mary C. Downing*  
(or) WIFE of

DATE OF BIRTH (month, day, and year) *Aug. 30-1848*

AGE Years Months Days *79 7 16* All LESS than 1 day, hrs or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Page Co. Va*  
(State or country)

10 NAME OF FATHER *John Downing*

11 BIRTHPLACE OF FATHER (city or town) *Va.*  
(State or country)

12 MAIDEN NAME OF MOTHER *Emiline Grimm*

13 BIRTHPLACE OF MOTHER (city or town) *Va*  
(State or country)

Informant *Mary C. Downing*  
(Address) *3322 Hudson*

Filed

1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 15 1928*

17

I HEREBY CERTIFY That I attended deceased from *March 12, 1928* to *March 14, 1928*

that I last saw him alive on *March 14, 1928*

and that death occurred, on the date stated above, at *11:30* A. M.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

*(Apoplexy)*

(duration) yrs. mos. ds.

CONTRIBUTORY *Arterio-sclerosis*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ☒  
if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical*

(Signed) *Henry B. Hays*, M. D.

*3/15, 1928* (address) *1504 20th St. N.W.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Mt. Carmel Cemetery*

DATE OF BURIAL

*3/18 1928*

20 UNDERTAKER

*George W. Zickler*

ADDRESS

*1737 E. Egan St.*

E 31705

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31705

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *26 Mallon Hill Rd. 28-66* WARD)2-FULL NAME *Joseph W. Rathrock*(a) RESIDENCE NO. *26 Mallon Hill Rd.*

(Usual place of abode)

Length of residence in city or town where death occurred *84* yrs. *2* mos. *19* ds.How long in U. S., if of foreign birth? *84* yrs. *2* mos. *19* ds.

WARD

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widower*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 26, 1844*7 AGE *83* Years

Months

Days

If LESS than 1 day, hrs. or min.

*84**2**19*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balt. Md.*

10 NAME OF FATHER

*William Rathrock*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balt.*

12 MAIDEN NAME OF MOTHER

*Victorine Smith*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balt.*

14

Informant (Address)

*Mrs. Minnie A. Kennedy 26 Mallon Hill Rd. Baltimore, Md.*

15

Filed

AR 16 1928

*R. H. H. Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 15, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 8, 1928*, to *March 15, 1928*, that I last saw him alive on *March 14, 1928*, and that death occurred, on the date stated above, at *11 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*CONTRIBUTORY (Secondary) *Hemiplegia* (duration) yrs. mos. *7* ds.18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical* (Signed) *John H. Davis*, M. D.1955 (Address) *612 N 40th St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

*Edw. W. Little*

DATE OF BURIAL

*March 17, 1928*

ADDRESS

*2708 Edmondson*



E 31706

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 100-001 E 31706

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 337 N. Calhoun St. 14-75 Ward)

2-FULL NAME Ruth A. Simms

(a) RESIDENCE NO. 337 N. Calhoun St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

Female Col'd Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 Filed

1928

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## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 March 15

17 I HEREBY CERTIFY That I took charge of the  
remains described above, held an inquest, autopsy or inquiry  
thereon and from the evidence obtained therefrom I find that said deceased came to death  
on the day stated above.  
The CAUSE OF DEATH\* was as follows:Broncho Pneumonia  
(duration) yrs. mos. 2 ds.CONTRIBUTORY  
(Secondary)Signed: M. B. Horton M. D.  
15-1928 (Address) Curtis Bay, Md.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt. Zion Cemetery Mar. 16, 1928

20 UNDERTAKER ADDRESS Mrs. Kate R. Williams 312 4 Schuchert St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31707

## CERTIFICATE OF DEATH.

31✓  
E 31707  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2211 Portugal St., 1-3 Ward)2-FULL NAME Joseph Dominick(a) RESIDENCE NO. 2211 Portugal St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. I mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Josephine Dominiak, (or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb. 15-1888.7 AGE Years 40 Months I Days 29 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.10 NAME OF FATHER Frank Dominiak,11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,12 MAIDEN NAME OF MOTHER Mary Pawlak,13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,14 Informant Josephine Dominiak, (Wife) (Address) 2211 Portugal St15 Filed 16-1928 HAMMON JONES, R. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said Inquest and that said deceased came from death (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)  
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)  
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence.....  
19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Date of Burial 3/17 1928.  
20 UNDERTAKER 911 J. Sadowski ADDRESS 705 S. Am. Dr

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31708

## CERTIFICATE OF DEATH.

90 E 31708

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2810 Fleetwood Ave ST. 27-43 WARD)2-FULL NAME Helen M. Scrami(a) RESIDENCE NO. 2810 Fleetwood Ave ST. 27-43 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds.How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Joseph ScramiDATE OF BIRTH (month, day, and year) Jan 27 1909

AGE

Years 29Months 2Days 16If LESS than  
1 day, hrs. 17  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) Baltimore10 NAME OF FATHER Joseph Krahovich11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Czechoslovakia12 MAIDEN NAME OF MOTHER Anna Lippa13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) CzechoslovakiaInformant  
(Address) Joseph Scrami  
2810 Fleetwood AveFiled 16 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 19 28, to March 14, 19 28,  
that I last saw him alive on March 14, 19 28,  
and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH\* was as follows:

Myocarditis(duration) 1 yrs. 0 mos. 0 ds.CONTRIBUTORY  
(Secondary) Chronic Valvular Heart Disease(duration) 3 yrs. 0 mos. 0 ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Joseph L. Vahutsky M. D.Address) 14 So Monmouth

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Holy RedeemerDATE OF BURIAL 3/17/2820 UNDERTAKER Philip HenryADDRESS 14 So Monmouth

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31709

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 5109 Wilson Ave St. 27 Ward)2-FULL NAME Joseph G. Dutrow(a) RESIDENCE NO. 5109 Wilson St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.74-001  
E 31709  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS			
1 SEX <u>Male</u>	4 Color or Race <u>White</u>	5 Single <u>Married</u>	6 Married, Widowed, or Divorced (write the word)
7 If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Ella G. Dutrow</u>			
8 DATE OF BIRTH (month, day, and year) <u>Jan. 29 1866</u>			
9 AGE	Years <u>62</u>	Months <u>1</u>	Days <u>16</u>
			IF LESS than 1 day _____ hrs. or _____ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railway Co.

BIRTHPLACE (city or town)

(State or country) Maryland10 NAME OF FATHER Samuel Dutrow

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Owne

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) MarylandInformant Ernest C. Dutrow(Address) 5109 Wilson AvenueFiled \_\_\_\_\_, 1928Registrar [Signature]

CORONER'S CERTIFICATE OF DEATH	
16 DATE OF DEATH (month, day, and year)	<u>3/5 1928</u>
17 I HEREBY CERTIFY, That I took charge of the remains described above, held an <u>Inquest</u> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <u>Inquest</u> (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.	
The CAUSE OF DEATH* was as follows: <u>Old age</u>	
(duration) _____ yrs. _____ mos. _____ ds.	
CONTRIBUTORY (Secondary) _____	
(duration) _____ yrs. _____ mos. _____ ds.	
(Signed) <u>[Signature]</u>	(Coroner) _____ M. D.
(Address) <u>502 E. North</u>	

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR \_\_\_\_\_ Date of Burial

Blue Ridge Pema 3/17 1928UNDERTAKER William Cook ADDRESS 502 E. North



E 31710

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3030 St. Paul

WARD)

## 2. FULL NAME

Amelia M. West

(a) RESIDENCE NO. 3030 St. Paul

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

 6 If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

None

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
90	--	--	--	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Baltimore  
Maryland

10 NAME OF FATHER ----- Hicks

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

Informant

W. Pinkney West

(Address)

3030 St. Paul St.

16 1928

19

C. HARRISON JONES, R. L.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 19 28

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 19 28, to March 15, 19 28,

that I last saw her alive on March 14, 19 28

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis  
Severe AtherosclerosisCONTRIBUTORY  
(Secondary)

(duration) yrs mos ds

(duration) yrs mos ds

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Palmer B Freeman, M. D.

, 19 (Address) 412 Cathedral St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Mount Cemetery

3/17 19 28

20 UNDERTAKER

ADDRESS

Henry W. Dears, Son 805 N. Calvert

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31711

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals 14 B. WARD)

2. FULL NAME Grace Bogle

(a) RESIDENCE NO. 612 Smith st.  
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos.

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Separated

If married, widowed, or divorced  
HUSBAND of Unknown  
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1904

AGE Years Months Days If LESS than 1 day, hrs. or min.  
23

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 070  
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown  
(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Charles Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Hoffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Hospital Records  
(Address)

Filed 1928 19 C. HARRISON JONES, R. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1928

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1927 to March 15, 1928

that I last saw her alive on March 15, 1928

and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Lab.

(Signed) L. E. Madden M. D.

3-15-28 (Address) Balto. City Hospitals.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mount Clearview  
UNDERTAKER

3-16-28  
ADDRESS

Daniel Eoster

116 Penn ave

31712

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001  
E 31712

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 10-14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annale Dets(a) RESIDENCE No. 820 Lewis  
(Usual place of abode)ST. 10-14 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female ColoredIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) ?

AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or min.

60

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) Maryland

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) ?Informant  
(Address) Records

Filed

1924  
HARRISON JONES, R. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/1928

17

I HEREBY CERTIFY That I attended deceased from  
Jan. 10, 1925, to Mar. 14, 1928,  
that I last saw him alive on Mar. 14, 1928and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. mos. 4 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ?  
if not at place of death?Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? General & Sal.(Signed) C. J. Holmes M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Mount Olivet3-15-28

20 UNDERTAKER

ADDRESS

Daniel CostinSt. James

31713

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 Otterbair ST. 21-29 WARD)REGISTERED NO. 31713

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annice Malone(a) RESIDENCE NO. 329 Otterbair

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleCalWidowed

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Wm Malone

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

36

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

Jno. Smith

11 BIRTHPLACE OF FATHER (city or town)

Va

(State or country)

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

unknown

(State or country)

Informant

(Address)

Ernest Palmer  
329 Otterbair St

Filed

16 1928Ernest Palmer

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 9, 1928, to Mar 14, 1928,that I last saw her alive on Mar 11, 1928,and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

None

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pelletier, M. D.

, 19

(Address) 817 Hamilton St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm Auburn Lane3/16/28Ernest Palmer817



E 31714 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *4-32*)ST. *4-32* WARD)2-FULL NAME *Mrs Kate Smith*

(a) RESIDENCE No.

*Eosee Ave Stimmers Run, Md*

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**white**Widow*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*John Smith*

DATE OF BIRTH (month, day, and year)

*June 14<sup>th</sup> 1854*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*73**9**1*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Balto. Maryland*  
*Maryland*

10 NAME OF FATHER

*John Taylor*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Maryland*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Unknown*Informant  
(Address)*Edward Leary*  
*Stimmers Run*

Filed

*16 1928**Register*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-15* 19*29*

17

I HEREBY CERTIFY, That I attended deceased from  
*3-10*, 19*28*, to *3-15*, 19*28*.that I last saw her alive on *3-15*, 19*28*.and that death occurred, on the date stated above, at *4 P* m.

The CAUSE OF DEATH\* was as follows:

*Strangulated femoral hernia*  
*(left)*(duration) yrs. mos. *2* ds.CONTRIBUTORY  
(Secondary)*Terminal lobular pneumonia*(duration) yrs. mos. *3* ds.18 Where was disease contracted  
if not at place of death?*at home*Did an operation precede death? *yes* Date of *3-10-28*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *John Roberto Phillips*, M. D., 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Oak Lawn Cemetery**March 18 1928*

20 UNDERTAKER

ADDRESS

*Frederick Leary & Sons* *Fullerton*

E 31715

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31715

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hosp. St. 16-68* WARD)2-FULL NAME *Mrs. Vida Wertz.*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2534 Arumrah Ave.* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Edward Wertz*6 DATE OF BIRTH (month, day, and year) *Sept 13, 1861*7 AGE Years *66* Months *6* Days *2* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *None*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Capt. Co. Md.*10 NAME OF FATHER *Benjamin Harrison*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balton Co Md*12 MAIDEN NAME OF MOTHER *Emilia Harrison*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balton Co Md*14 Informant (Address) *Hospital Records*15 1928 *C. HAMMON JONES, M.D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-15-28* 1917 I HEREBY CERTIFY, That I attended deceased from *3-8-28*, 19, to *3-15-28*, 19,that I last saw her alive on *3-15-28*, 19,and that death occurred, on the date stated above, at *10:30* A. M.

The CAUSE OF DEATH\* was as follows:

*Generalized Peritonitis Secondary to Empyema of gall Bladder*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Myocardial Infarction*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *yes* Date of *3-9-28*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Frederick M. Hall*, M. D.(Address) *Franklin Sq. Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Woodlawn Cemetery* DATE OF BURIAL *Mar 17, 1928*

20 UNDERTAKER

*Wm. J. McKelvey* ADDRESS *North St.*

E 31716

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31716

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 106 Rochester Pl. St., 1-2 Ward)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) Residence No. 106 St.,

(Usual place of abode)

Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

1-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced. (Write the word.)

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE,

If LESS than 1 day,

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer.

9-BIRTHPLACE (city or town), (State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (city or town), (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town), (State or Country),

(Informant)

(Address)

1928

HARRISON JOHNSON

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

17-

I HEREBY CERTIFY, That I attended deceased from

March 14, 1928, to March 16, 1928.

that I last saw him alive on March 16, 1928.

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Schlegel M. D.

1928 (Address) 330 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

Mrs. C. Miller 2334 Jefferson St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31717

31717

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4715 Locust Ave St. 27-48 Ward)

Registered No. ....

## 2-FULL NAME

(a) Residence No. ....

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-Single  
Married  
Widowed  
or Divorced.  
(Write the word.)6a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE.

If LESS than 1 day.

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town).  
(State or Country).10-NAME OF  
FATHER.11-BIRTHPLACE  
OF FATHER (city or town).  
(State or Country).12-MAIDEN NAME  
OF MOTHER.13-BIRTHPLACE  
OF MOTHER (city or town).  
(State or Country).

14-

(Informant)

(Address)

15-

Filed

1928

HARRISON J. JONES, R. L.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year).

17- I HEREBY CERTIFY, That I attended deceased from

March 9, 1928, to March 11, 1928.

that I last saw him alive on March 11, 1928.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis - Ch. of Myocarditis -  
Ch. MyocarditisCONTRIBUTORY  
(Secondary)18-Where was disease contracted  
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Mar 16, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL

DATE OF BURIAL

20-UNDERTAKER.

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31718

E 31718

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *112 East 20<sup>2</sup>* ST. *12-19* WARD)2-FULL NAME *Charles August Ohrenschall*(a) RESIDENCE NO. *112 East 20<sup>2</sup>*

(Usual place of abode)

Length of residence in city or town where death occurred *70* yrs. *8* mos. *16* ds.ST. *12-19*

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widower*

If married, widowed, or divorced HUSBAND of (or) WIFE of

*of the late Minnie M. Ohrenschall*DATE OF BIRTH (month, day, and year) *June 27/1857*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*70**8**16*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*August Ohrenschall*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Helmine Rothe*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

Informant

(Address)

*Charles S. Ohrenschall  
112 East 20<sup>2</sup> St*

Filed

*1928*

19

*C. HAMPTON JONES, R. L.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 14<sup>th</sup> 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 11*, 1928, to *Mar 14*, 1928,that I last saw him alive on *Mar 14*, 1928,and that death occurred, on the date stated above, at *10.30 a.* m.

The CAUSE OF DEATH\* was as follows:

*bronchopneumonia*(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

*Chronic Infectious Nephritis*(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Signs, Chemistry*(Signed) *W. H. Jones*

M. D.

, 19

(Address)

*2439 N Charles St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**3/17/1928*

FUNERAL

ADDRESS

*Geo. Weber & Son 2503 Edmondson*

E 31719

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31719

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 W Lexington

ST. 18-76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ursule Paplauskas

(a) RESIDENCE NO. 742 W Lexington

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX F	4 COLOR OR RACE W	5 Single, Married, Widowed, or Divorced, (write the word) Married
----------	----------------------	---

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Mar No. 1889

AGE 39	Years	Months	Days	If LESS than 1 day, hrs. or min.
--------	-------	--------	------	--

## OCCUPATION OF DECEASED

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Tailor

(c) Name of employer No.

BIRTHPLACE (city or town) Lithuania  
(State or country)

10 NAME OF FATHER Vincent Mazeika

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Veronika Buzute

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) LithuaniaInformant M. Uaksa  
(Address) 742 W Lexington St.

1928

C. HAMMON JONES, R. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1928

17

I HEREBY CERTIFY, That I attended deceased from  
May 1927, to March 15, 1928,  
that I last saw her alive on March 15, 1928,  
and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Cerebral Hemorrhage  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. Buchness, M. D.

19 (Address) 37 S. Stricker St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Holy Redeemer

March 20, 1928

20 UNDERTAKER

ADDRESS

John Grebliauckas

423 S Paca St.

31720

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31720

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 E Chase

ST., 7-13 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME CHARLES J. Penner

(a) RESIDENCE NO. 1603 E Chase

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 8, 1926

AGE 1 Years 6 Months 25 Days

If LESS than 1 day, hrs or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

No

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER John Penner

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Nelen Anzula

13 BIRTHPLACE OF MOTHER (city or town) Pittsburgh Pa. (State or country)

Informant N. Penner

(Address) 1603 E Chase Street

Filed

19

CHAMBERLAIN JONES, K. D.

Registrar

7-13

ST., WARD

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15/28

17

I HEREBY CERTIFY, That I attended deceased from March 2/28, 19, to March 15/28, 19, that I last saw him alive on March 15/28, 19, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. D. Colburn, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer

20 UNDERTAKER

John Grebliauckas

DATE OF BURIAL

March 17, 1928

ADDRESS

423 S Paca St

E 31721

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31721

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1602 N. Montford* ST. *8-16* WARD)

## 2. FULL NAME

*Marion B. Adams*

## (a) RESIDENCE NO.

*1602 N. Montford Ave*

Length of residence in city or town where death occurred

yrs. *1*mos. *1*

ds.

ST., WARD

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Feb 16<sup>th</sup> 1927*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**1*

## OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 8 BIRTHPLACE (city or town) (State or country)

*Baltimore*

## 10 NAME OF FATHER

*Charles Adams*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*St Mary's*

## 12 MAIDEN NAME OF MOTHER

*Benedicta Bean*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*St Mary's*

## Informant (Address)

*Charles Adams 1602 N. Montford Ave*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 16 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from *March 11 1928* to *March 16 1928*, that I last saw him alive on *March 15 1928*, and that death occurred, on the date stated above, at *10 P. m.*

## The CAUSE OF DEATH\* was as follows:

*Bronchopneumonia (bilateral)*(duration) yrs. mos. *6* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

*1602 N. Montford Ave*

## Did an operation precede death?

*No*

Date of

## Was there an autopsy?

*No*

## What test confirmed diagnosis?

*No special test*

## (Signed)

*Jack H. Hargrave* M. D.

## (Address)

*316 1928 6-E 4th St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Baltimore Cemetery*

## DATE OF BURIAL

*March 17<sup>th</sup> 1928*

## 20 UNDERTAKER

*Frank V. Reestone*

## ADDRESS

*247 E. Baltimore*

1928

G. HANCOCK JONES, Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE 31722

31722

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (N. 2213 Hammond ST. 8-45 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 2213 Hammond ST. WARD

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-21-1855

7 AGE Years 73 Months 2 Days 23 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address)

Filed

19 BALTIMORE JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 14 1928

17

I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1927, to Mar. 13, 1928, that I last saw him alive on March 13, 1928,

and that death occurred, on the date stated above, at 4 A. M. The CAUSE OF DEATH\* was as follows:

Sarcoma Cervical Glands - (Metastases)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathological Report

(Signed) Edgar P. Sandercock, M. D.

, 19 (Address) Medical ARTS Building

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

J. A. Moran

3/17/1928  
3090 E. Baltch

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31723

## CERTIFICATE OF DEATH

90 E 31723

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 557-6-38 St. 9-46 Ward)2-FULL NAME Ann Marie Henry(a) RESIDENCE NO. 557-6-38 St. 9-46 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.4 Color or Race W.5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Henry6 DATE OF BIRTH (month, day, and year) Dec. 8-1862

7 AGE

Years 65Months 3Days 6

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland10 NAME OF FATHER John Barth

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14

Informant (Address) Ann Henry15 Filed 1326

19

APR

Register

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1928

17

I HEREBY CERTIFY, That I attended deceased from Dec 1- 1926, to Mar 14 1928that I last saw her alive on Mar 13- 1928and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 mo.(duration) yrs. mos. 2 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What was the confirmed diagnosis? Myocardial InfarctionSigned J. G. Moran(Address) 143701 3rd Ave, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS 3000 E. Baltimore

31724

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 W. Baltimore

ST., 19-28 WARD)

2-FULL NAME Joseph Elmer Doyle

(a) RESIDENCE NO. 1723 W. Baltimore

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 8, 1927

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

---

3

7

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore

Maryland

10 NAME OF FATHER Joseph L. Doyle

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore

Maryland

12 MAIDEN NAME OF MOTHER Mary Plateau

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Richmond

Virginia

Informant  
(Address)

Mr. J. L. Doyle

1723 W. Baltimore St.

1928

C. HAMPTON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 14, 1928, to Mar 15, 1928.

that I last saw him alive on Mar 15, 1928.

and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH\* was as follows:

Acute Broncho  
(Primary) Pneumonia  
(duration) yrs. mos. 2 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. C. Campbell, M. D.

19 (Address) 1644 S. Harbover Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Loudon Park

2 UNDERTAKER

Joseph B. Cook

DATE OF BURIAL

Mar. 17, 1928

ADDRESS

1003 W.

Baltimore St

31725

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31725

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1740 Johnson

ST. 24-34 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles I. Wingate.

## (a) RESIDENCE NO.

1740 Johnson

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

19 yrs. 4 mos. 3 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male.

White.

Single.

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Single.

DATE OF BIRTH (month, day, and year)

Nov. 11, 1908.

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

19.

4.

3.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Roofer. Enterprise

(b) General nature of industry, business, or establishment in which employed (or employer)

Roofing Co.

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Balto. Md.

## 10 NAME OF FATHER

John E. Wingate.

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balto. Md.

## 12 MAIDEN NAME OF MOTHER

Mary A. Curley.

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Balto. Md.

Informant  
(Address)Mary A. Wingate, (Mother).  
1740 Johnson St.

1928

C. HAMMOND JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 14 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar. 1, 1928, to Mar. 14, 1928.

that I last saw him alive on Mar. 14, 1928.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. L. Hays, M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Cedar Hill Cemetery 171928  
A. Howard Evans 30 E. Fort Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

JOHNS HOPKINS HOSPITAL

ST., \_\_\_\_\_

WARD) \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Howard Sexton

## (a) RESIDENCE NO.

Lasonville, Ind.

(Usual place of abode)

ST., \_\_\_\_\_

WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

How long in U. S., if of foreign birth?

yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
Divorced, (write the word)

Married

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Sylvia

DATE OF BIRTH (month, day, and year)

1900

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

28

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

coal miner

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Kentucky

10 NAME OF FATHER

William Sexton

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ky

12 MAIDEN NAME OF MOTHER

Mary Bryant

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ky

Informant  
(Address)

Records

FEB 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 16 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar. 12, 1928, to March 16, 1928,

that I last saw him alive on March 16, 1928,

and that death occurred, on the date stated above, at 12 05 P.M.

The CAUSE OF DEATH\* was as follows:

Brain Tumor - Hypophyseal  
tumor - Benign

(duration) 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? yes Date of Mar 16, 1928

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed)

Lymon M. M.D.

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Lasonville Ind.

DATE OF BURIAL

3/17/28

20 UNDERTAKER

Joseph Ahrens

ADDRESS

221 Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31727

## CERTIFICATE OF DEATH.

X 8 E 31727

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 7-9 Ward)2-FULL NAME Thomas Greene Terry

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 1301 11th St., Lynchburg, Va. Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed,  
or Divorced, (write the word)  
Single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 16/1892

7 AGE

Years

35

Months

5

Days

0

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....

Shoe Manufacturer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

Cradack-Terry Co.

9 BIRTHPLACE (city or town).....

(State or country)

Lynchburg &amp; Va.

10 NAME OF FATHER

T. M. Terry

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Lynchburg, Va.

12 MAIDEN NAME OF MOTHER

Champe Pryor

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Charlottesville, Va.

14

Informant  
(Address)

Dr. T. P. Sprunt

107 Norwood Road

15 REGISTRAR  
C. HAMMON JONES, R. D.  
1328

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

192

March 16/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-topsy or inquiry.) and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Hemorrhage-Glioma Right Occipital  
Lobe Cerebrum

(Autopsy at Hopkins Hospital)

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

M. D.

3/16/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Lynchburg Va

Mar 16 1928

20 UNDERTAKER

ADDRESS

Henry H. Jenkins

m. jenkins

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31728

## CERTIFICATE OF DEATH

E 31728

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1424 E. Pratt St. St. 3-4 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1424 E. Pratt St. St. 3-4 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

March 5, 1925

7 AGE

3

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

2

11

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Thomas J. Jaggars

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Wilmington Del.

12 MAIDEN NAME OF MOTHER

Mary Calatta

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Thomas J. Jaggars

15

Filed

1928

19

J. E. Jones

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 15, 1928

19

1928

17

I HEREBY CERTIFY, That I attended deceased from

March 13, 1928, to March 1, 1928

that I last saw him alive on March 15, 1928

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho. Pneumonia

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary)

Impacts

(duration) yrs. mos. 2 da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. Volin

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

Date of Burial

March 17, 1928

20 UNDERTAKER

Wendell J. Lupinel

ADDRESS

3018 Calvert

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31729

E 31729

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 N. Lombard)

ST. 19-28 WARD

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina G. Arnold

(a) RESIDENCE NO. 1402 N. Lombard  
(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Chief

If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) June 29-1926

AGE Years Months Days If LESS than 1 day, hrs. or min.  
1 8 15

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Ordon B. Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary McKenney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

Informant Mary C. Arnold  
(Address) 1402 N. Lombard

1928

REGISTRAR George J. Smith

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11-1928

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1928, to March 11, 1928, that I last saw her alive on March 11, 1928, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Septic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? Physical signs  
(Signed) Allen Beaman M. D.

3-16-1928 (Address) 3739 E. Baltimore, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1532 Hollin



HEALTH DEPARTMENT—CITY OF BALTIMORE, MD  
E 31730

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Dr. White's Hospital  
CITY OF BALTIMORE: (No. 1029 Madison Ave. ST. 11-24 WARD)  
2-FULL NAME Sadie Barrett  
REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1116 Madison Ave. ST. WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1872

7 AGE 56 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John W. Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Grace Watters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas Scott (Address) Belair Md

15 1928 C. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1928

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1928, to March 13, 1928.

that I last saw her alive on March 13, 1928.

and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH\* was as follows:

Strangulated Hernia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY Intestinal Volvulus & Perforation (Secondary) (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. White M. D.

, 19 (Address) 1029 Madison Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL Mountaineer Co. Md DATE OF BURIAL 3-17-28

20 UNDERTAKER Harford Co. Md ADDRESS 1027

John H. Traden Ham Hill

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31731

## CERTIFICATE OF DEATH.

E 31731

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 21-29 Ward)

## 2-FULL NAME

Charles Abraham

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 721 Dover St

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

male col single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10/1927

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 7 5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

10 NAME OF FATHER Namey Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Alverta Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Father (Address)

17 1828

19 HARRISON JONES, V. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15-28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

Inquiry and that said deceased came his death (Inquest, au-

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia- Otitis Media- Ricketts.

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

3-16-28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt Zion cemetery March 17 28

20 UNDERTAKER

Edward Bryan

ADDRESS 1631 Orleans St

E 31732

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31732

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1402 Light* St. *23-31* Ward)Registered No. *92*

## 2-FULL NAME

(a) Residence No. *1402 Light St.*

(Usual place of abode)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *27* yrs. *10* mos. *22* ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE

*White*

5-Single, Married, Widowed, or Divorced.

*Single*  
(Write the word.)

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

*April 22<sup>nd</sup> 1900*

7-AGE

*27* yrs. *10* mos. *22* ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Stenographer*

9-BIRTHPLACE (city or town) (State or Country)

*Balto*

10-NAME OF FATHER

*William H. Decker*

11-BIRTHPLACE OF FATHER (city or town) (State or Country)

*Balto*

12-MAIDEN NAME OF MOTHER

*Catherine Trier*

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

*Balto*

14- (Informant)

*William H. Decker*

(Address)

*1402 Light St*

15-

*1928*

C. HARRISON JONES, M. D.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *March 14<sup>th</sup> 1928*

17- I HEREBY CERTIFY, That I attended deceased from

*Mar 8* 19*28* to *Mar 14* 19*28*that I last saw him alive on *Mar 14* 19*28*and that death occurred, on the date stated above, at *7 P.* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma  
Thrombosis*(Duration) yrs. mos. ds. *8 mos.*

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. H. Gresham* M. D.*Mar 16, 1928* (Address) *1305 Light St*

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Burial**March 17, 1928*

20-UNDERTAKER

ADDRESS *1034**Schloman & Son* *Chambers St*

E 31733

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *26th St & 5th Ave*)

## 2. FULL NAME

*Charles E Schaper*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

*Life* yrs.

mos.

ds.

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

*Elizabeth Schaper 1864*

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Woodworker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Lafayette Mills*

BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*Henry Schaper*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md*

12 MAIDEN NAME OF MOTHER

*Rachel M Barrett*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md*

Informant (Address)

*Elizabeth Schaper 26th & 5th Ave*

1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 17 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 10 1928*, to *March 17 1928*that I last saw him alive on *March 17 1928*and that death occurred, on the date stated above, at *4:00* m.

The CAUSE OF DEATH\* was as follows:

*Influenza*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

*Double Pneumonia*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*W. E. McClanahan M.D.*

(Address)

*3505 Bank St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*Stouidon Park 16*  
*William Cook 16**3/17 1928**507 E North*



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31734

## CERTIFICATE OF DEATH.

129E 31734

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 N. Appleton ST. 6-42 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 8206 Appleton ST. 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 1/2 yrs. 00 mos. 00 ds. How long in U. S., if of foreign birth? (If non-resident give city or town and State) yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <i>M</i>	4 COLOR OR RACE <i>W</i>	5 Single, Married, Widowed, or Divorced, (write the word) <i>M</i>
-----------------	-----------------------------	--

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 21, 1865

AGE	Years	Months	Days	If LESS than 1 day, .... hrs. or min.
	63	10	34	

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... *A. L. Horne*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) ...  
(State or country) ...

10 NAME OF FATHER *James H. Shaw*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *London*

12 MAIDEN NAME OF MOTHER *Ellen G. O.*

13 BIRTHPLACE OF MOTHER *City & town*  
(State or country)

Informant Arthur E. Grohman  
(Address) 200 E. 11th St.

Filed: 1928 11-19 HAMPSON, JONES, N. D. Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) Mar 15 19 38

17

I HEREBY CERTIFY, That I attended deceased from  
41 - , 1927, to Mar 15, 1928.  
that I last saw h 41 alive Mar 14, 1928,  
and that death occurred, on the date stated above, at 8 a. m.

CHIEF CAUSE OF DEATH was as follows:

*Chronic Nephritis*

(duration) ... 2 yrs. ... mon ... ds

**CONTRIBUTORY**  
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted  
if not at place of death? .....

Did an operation precede death? ☒ Date of ☒

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? *Chemical screen*

(Signed) E. Heller Therapist, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL ☒ RE- ☐ DATE OF BURIAL

NO UNDERTAKER ADDRESS

11 Cook 507 E. Mark

E 31735

# HEALTH DEPARTMENT—CITY OF BALTIMORE

84 E 31735

## CERTIFICATE OF DEATH.

### I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2915 Chelsea Terrace* ST. *15-61* WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Belle Loos*

(a) RESIDENCE NO. *East Liberty Pittsburgh* ST. *Penna* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *4* mos. ds. How long in U. S., if of foreign birth? *1* yrs. *4* mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *F.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Jan 28, 1868*

AGE Years *60* Months *1* Days *16* If LESS than 1 day, hrs or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Teacher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Lewisburg, Penna* (State or country)

10 NAME OF FATHER *Alexander Loos*

11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)

12 MAIDEN NAME OF MOTHER *Marion E. Mead*

13 BIRTHPLACE OF MOTHER (city or town) *N.Y. State* (State or country)

Informant *Julia C. Loos* (Address) *2915 Chelsea Terrace*

1928 C. HAMMON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 16 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Jan. 28*, 1928, to *Mar. 16*, 1928, that I last saw him alive on *Mar. 16*, 1928

and that death occurred, on the date stated above, at *11:45 a* m.

The CAUSE OF DEATH\* was as follows:

*2nd deg Anemia*

*first registered by laboratory*  
(duration) *9* mos yrs. *8* mos ds.  
*Delusional*  
CONTRIBUTORY *Paralysis agitans*  
(Secondary) (duration) *1* yrs. *11* mos. ds.

18 Where was disease contracted if not at place of death? *Pittsburgh Penna*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Symptoms & laboratory*  
(Signed) *Julia C. Loos*, M. D.  
19 (Address) *2915 Chelsea Terrace*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
*Philadelphia Pa* DATE OF BURIAL *Mar 17 1928*

20 UNDERTAKER *J. Jackson Jones* ADDRESS *704 E*

E 31736

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 101  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1940 N Patterson Pl ST. 8-16 WARD)

2-FULL NAME Lake B Chelton

(a) RESIDENCE NO. 1940 N Patterson Pl ST. 8-16 WARD  
 (Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed,  
 or Divorced, (write the word) Single

5a If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1899

7 AGE Years Months Days If LESS than  
31 1 3 1 day, hrs.  
 or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
 particular kind of work

(b) General nature of industry,  
 business, or establishment in  
 which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
 (State or country) Maryland

10 NAME OF FATHER Geo W Chelton

11 BIRTHPLACE OF FATHER (city or town)  
 (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Chelton

13 BIRTHPLACE OF MOTHER (city or town)  
 (State or country) Md.

Informant Emma Chelton  
 (Address) 1940 N Patterson Pl

1928 G. HAMMON JONES, M. D.  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-15 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 10, 1928, to Mar 10, 1928,  
 that I last saw him alive on Mar 10, 1928,  
 and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH\* was as follows:

Labor Pneumonia

CONTRIBUTORY  
 (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted  
 if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical  
 (Signed) W. H. Campbell M. D.

3/16, 1928 (Address) 1644 Haverhill

\*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Edgar Hill  
1158 West St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31737

E 31737

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *421 E Clement* *24-33* Ward)2-FULL NAME *Henry A. Schreiner Jr.*(a) RESIDENCE NO. *421 E Clement* St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Feb 4 1928*

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.*1 12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*none*

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Henry Schreiner*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Balto Md*

12 MAIDEN NAME OF MOTHER

*Marie Blumstein*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto Md*

14

Informant  
(Address)*Henry Schreiner  
421 E Clement St*

15 Filed

1928

G. HAMPSON JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-16-28*

I HEREBY CERTIFY, That I attended deceased from

*Mar 14 1928* to *Mar 16 1928*that I last saw him alive on *Mar 15 1928*and that death occurred, on the date stated above, at *7 40 A m.*

The CAUSE OF DEATH was as follows:

*Bronchopneumonia*CONTRIBUTORY  
(Secondary)

Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Autopsy*

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Holy Cross O.C.C.**3-17 1928*

20 UNDERTAKER

ADDRESS

*Est 3 Mar 15 E 7224 St*



E 31738

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31738

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mar 14 264. Lafayette St. Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 264. Lafayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Turner6 DATE OF BIRTH (month, day, and year) Antenatal7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 44

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ba Md10 NAME OF FATHER Wm Wiggins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md12 MAIDEN NAME OF MOTHER Turner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

PARENTS

14

Informant (Address) Ed. Turner  
264. Lafayette St.

15

19

1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy, or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Prob. Valv. dis. heart

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Wm. H. Riley M. D.

(Coroner)

20115  
1928 (Address) 1039 Queen St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Lukes Mar. 17, 1928  
20 UNDERTAKER Wm. H. Riley ADDRESS 1725 Ashland Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31739

## CERTIFICATE OF DEATH.

E 31739

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1571 Lemmon St. 19-28 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Cold 5 Single, Married, Widowed, or Divorced. (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
2 16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filing

G. HANCOCK JONES, R. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, and made a report thereon and from the evidence obtained by inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Infantile Convulsions

CONTRIBUTORY (Secondary)

Signed John B. Norton M. D.15, 1928 (Address) Quart's Bay,

\*State the Disease Causing Death, or in death, from Causes, state (1) Means and Nature of death, (2) Mental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

W. Auburn Cem March 19 1928

20 UNDERTAKER

A. Jones

ADDRESS

1115 Gelyon

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31740

E 31740

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1708 John St. St. 14-20 Ward)

## 2-FULL NAME

Mary Givins

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1708 John

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 0 mos. 0 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female white widow

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William Givins

## 6 DATE OF BIRTH (month, day, and year)

Mar 21. 1844

## 7 AGE

Years

Months

Days

831126

IF LESS than 1 day.....hrs. or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Ireland

(State or country)

## 10 NAME OF FATHER

Thomas Kearse

## 11 BIRTHPLACE OF FATHER (City or town)

England

(State or country)

## 12 MAIDEN NAME OF MOTHER

Ann Coleman

## 13 BIRTHPLACE OF MOTHER (city or town)

Ireland

(State or country)

## 14

Informant (Address)

Edith H. Elliott  
1708 John St.

## 15

Filed

19

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

March 16. 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

June 19. 27 to March 15. 1928that I last saw her alive on March 15. 1928and that death occurred, on the data stated above, at 6.00 a.m.

The CAUSE OF DEATH\* was as follows:

General ParesisSeveral months  
(duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

Organic Heart Trouble  
(duration) yrs. mos. da.

## 18 Where was disease contracted

if not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? none

(Signed)

Henry M. Bayless, D.

(Address)

1205 N. Calver St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Landon ParkMar 19. 1928

## 20 UNDERTAKER

ADDRESS

John Mitchell & Son

31741

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 N. Paterson PK Ave ST. 8-16 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

29 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

29 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Agnes Rezek

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Retired

9 BIRTHPLACE (city or town) (State or country)

Czechoslovakia

10 NAME OF FATHER

John Rezek

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Czechoslovakia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Agnes Rezek 1200 N. Paterson PK Ave

15

1928

BALTIMORE, MD.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 3 1928 to Mar. 15 1928

that I last saw him alive on Mar. 14 1928

and that death occurred, on the date stated above, at 2<sup>19</sup> A. m.

The CAUSE OF DEATH\* was as follows:

Cirrhosis of Liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Vincent J. Jones, M. D.

, 19 (Address) 845 N. Paterson PK Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Hill

DATE OF BURIAL

Mar 18 1928

20 UNDERTAKER

Frank Crockett

ADDRESS

1706 Ashland



E 31742

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31742

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3903 Falls Road ST. 13 WARD)

2-FULL NAME Joseph F. Wilson

(a) RESIDENCE No. 3903 Falls Road

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds.

ST. 13 WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. 0 mos. 0 ds.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie F. Wilson

DATE OF BIRTH (month, day, and year) June 4-1841

AGE

Years 80

Months 9

Days 12

If LESS than 1 day, hrs. 0 or min. 0

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelwright

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 10 years

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Delaware

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant (Address) Mrs. Bessie M. Carter

File 71926

C. HAMMOND JOHNSON

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1928

17

I HEREBY CERTIFY, That I attended deceased from February 26, 1928 to March 16, 1928, that I last saw him alive on March 15, 1928, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis  
acute cardiac dilatation

(duration) yrs. 0 mos. 0 ds.

CONTRIBUTORS (Secondary) arteriosclerosis, Myocarditis

(duration) yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. A. Macdonald, M. D.

, 19 (Address) 4037 Falls Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Woodlawn

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Horace F. Burgee 3631 Falls Rd.

E 31743

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31743

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *832 Aiequith* ST. *10-14* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Emma Louise Sprattley*

## (a) RESIDENCE NO.

*832 Aiequith St*

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*M**C**Married*

a If married, widowed, or divorced

HUSBAND of

or) WIFE of

*John E. Sprattley*

DATE OF BIRTH (month, day, and year)

*Aug. 12th 1888*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*39**1**3*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Delmar Heights, Va.*

## 10 NAME OF FATHER

*Charles Godwin*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Delmar Heights, Va.*

## 12 MAIDEN NAME OF MOTHER

*Louisa Carrel*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Va.*

Informant (Address)

*John E. Sprattley, Husband  
832 Aiequith St*

AR 17 1928

*CHAMBERLAIN JONES  
Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 15 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 15 1928 to March 15 1928*that I last saw him alive on *March 15 1928*and that death occurred, on the date stated above, at *1:00 A. M.*

The CAUSE OF DEATH\* was as follows:

*D. Leuco*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*no*Did an operation precede death? *no* Date ofWas there an autopsy? *Physical*What test confirmed diagnosis? *yes*

(Signed)

*George S. Allen*

M. D.

Maid 1928 (Address)

*508 Somerset St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*Asbury Cem**3/17 1928*

## 20 URBERTAKER

## ADDRESS

*Byron H. Knight 1218 McElderry St*

HEALTH DEPARTMENT—CITY OF BALTIMORE **E 31744****31744**

## CERTIFICATE OF DEATH.

**38**

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Harry Pearson(a) RESIDENCE NO. 1173 Mc Eldery

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleNegro✓

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26/28 19

17

I HEREBY CERTIFY, That I attended deceased from

2/23/28, 19 to 2/26/28, 19that I last saw him alive on 2/26/28, 19and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Lawrence Fahnestock M. D.19 (Address) St Joseph's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL MAR 17 1928

20 UNDERTAKER

ADDRESS

Commissioner Health.

Per Wm. R. WOODALL

**1928****JOHNS HOPKINS HOSPITAL**

Register

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31745

E 31745

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Belt ST. 24-34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Katharine Beall(a) RESIDENCE NO. 1617 Belt

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Edward S. Beall6 DATE OF BIRTH (month, day, and year) Oct. 30<sup>th</sup> 1875

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.57414

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

W. Va.

10 NAME OF FATHER

Chas. J. Thomas

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Elle Dippenderfer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

W. Va.

14 Informant (Address)

Edw. Beall  
1617 Belt St.

15 F 1928

16 HANSON JONES, JR.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar. 15<sup>th</sup> 1928 to Mar. 15<sup>th</sup> 1928 that I last saw her alive on Mar. 14<sup>th</sup> 1928and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH\* was as follows:

Acute cardiac dilatation

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Chorea

(Signed)

19 Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Calver Hill Cemetery3/17/1928

20 UNDERTAKER

ADDRESS

E. J. Fanning & Son - 1460 Battery Ave



## E 31746 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31746

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

422 Rosedale Terrace ST. 71 WARD

## 2-FULL NAME

Pauline Rosina Fleischer

(a) RESIDENCE No.

422 Rosedale Terrace ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

62 yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Cauc White

Widow

If married, widowed or divorced HUSBAND of (or) WIFE of

Frederick Fleischer

DATE OF BIRTH (month, day, and year)

Feb. 20, 1843

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

85

0

24

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

George Lickke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Johanna

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

Informant (Address)

Mrs Anna Carroll 422 Rosedale Terrace

Filed

1928

P. R. R.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 15 1928

17

I HEREBY CERTIFY, That I attended deceased from July 29-1927, to Mar 15, 1928, that I last saw her alive on March 15, 1928.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

Cancer of the Stomach.

(duration) 7 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. H. M. D.

19 (Address) Frederick &amp; Augusta

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cem.

DATE OF BURIAL

Mar 17, 1928

20 UNDERTAKER

Wm. H. H. H. H. H.

ADDRESS

H. H. H. H. H.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31747

E 31747

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home & Infirmary* ST. *12-19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Leroy Mayes*(a) RESIDENCE NO. *1807 Guilford Ave.* ST. *12-19* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*

5a If married, widowed, or divorced

HUSBAND of

(or ~~WIFE~~)*Virginia Mayes*

6 DATE OF BIRTH (month, day, and year)

*Feb. 4, 1883*

7 AGE

Year

Months

Days

If LESS than 1 day, hrs. or min.

*45**-**1**13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Engineer*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Contracting*

(c) Name of employer

*20. Md. Const. Co.*

9 BIRTHPLACE (city or town) (State or country)

*Balto. Co., Md.*

10 NAME OF FATHER

*Wm. M. G. Mayes*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Balto. Co., Md.*

12 MAIDEN NAME OF MOTHER

*Sallie Biersol*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto. Co., Md.*

14

Informant (Address)

*Virginia Mayes 1807 Guilford Ave.*

15

Filed

*CHAMBERLAIN, R. D. Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 17 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*12-25, 1928, to March 17, 1928.*that I last saw him alive on *3-17, 1928.*and that death occurred, on the date stated above, at *9 A. m.*

The CAUSE OF DEATH\* was as follows:

*Ruptured gastric ulcer. Peritonitis.*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Terminal pneumonia*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Dec 25, 1927*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. H. Tattersdale, M. D.*19 (Address) *Church Home & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Joseph P. Church, Balto. Co.**Mar. 20, 1928*

20 UNDERTAKER

ADDRESS

*Wm. L. Brooks Sparks*

24 38/  
E 31748

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31748

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITALST. 7-9 (WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H. Luck(a) RESIDENCE NO. 18 Baltimore St.

(Usual place of abode)

ST. HyattsvilleWARD Hyattsville

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

WidowedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.79

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Canada10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)Records -

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar - 16 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb - 21, 1928, to March 16, 1928.that I last saw him live on March 16, 1928,  
and that death occurred, on the date stated above, at 8 30 P.M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia(duration) yrs. mos. 4 ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. 2 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? yes Date of Feb. 24, 1928Was there an autopsy? yesWhat test confirmed diagnosis? Autopsy(Signed) J. H. Keopitel M. D., 19 (Address) J. H. Keopitel

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Hyattsville MdMar 16 1928

UNDERTAKER

ADDRESS

Geo. L. Schwab 2121 Fredk Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31749

E 31749

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 405 n. Bond  
CITY OF BALTIMORE: (No. 405 n. Bond) ST. 6-9 WARD) REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Lee  
(a) RESIDENCE NO. 405 n. Bond ST. WARD (If non-resident give city or town and State)  
(Usual place of abode)  
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Lee

6 DATE OF BIRTH (month, day, and year) Mar. 1, 1860

7 AGE Years 68 Months 13 Days 13 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 010

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge, Md. (State or country)

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town) Cambridge, Md. (State or country)

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) Cambridge, Md. (State or country)

14 Informant Anne Hill (Address) 405 n. Bond

15 C. HAMMON JONES, R. D. Registrar  
1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 14, 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1928, to Mar. 14, 1928, that I last saw her alive on Mar. 14, 1928, and that death occurred, on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH\* was as follows:

Exophthalmic goitre

(duration) 20 yrs. mos. ds.

CONTRIBUTORY Ante Myocarditis (Secondary)

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Ex.

(Signed) W. L. Perry, M. D.

, 19 (Address) 1420 E. Chase

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL Mount Calvary 3/17/28

20 UNDERTAKER Mrs. R. A. Elliott 1722 Ashland



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31750

31750

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Hamilton ST., 43 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Storer(a) RESIDENCE NO. 3808 Hamilton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

Lepton Z StorerDATE OF BIRTH (month, day, and year) July 24AGE Years 28 Months 8 Days 13 If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Md.10 NAME OF FATHER Peter Perry11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.12 MAIDEN NAME OF MOTHER Elizabeth Brown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.Informant Harvey Storer (Address) 3808 HamiltonFiled 7 1928 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 192817 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1928, to March 15, 1928.that I last saw him alive on March 15, 1928and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhages  
1st - Feb 28 - 2nd Mar 10(duration) yrs. mos. 16 ds.CONTRIBUTORY (Secondary) Respiratory Paralysis(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Stanish J. Kelly M. D., 19 (Address) 1609 Linden Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Carroll G. Md  
Pipe Creek Cemetery

20 UNDERTAKER

W M RoutonDATE OF BURIAL Mar 18 1928ADDRESS 2238 W  
Smith

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31751

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *116 N. Dallas* ST., *6-9* WARD)2-FULL NAME *Joseph Dace*(a) RESIDENCE (Usual place of abode) *No. 116 N. Dallas*Length of residence in city or town where death occurred *40* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *colored* 5 Single, Married, Widowed, or Divorced, (write the word) *widowed*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Eleanor Dace*6 DATE OF BIRTH (month, day, and year) *1873*7 AGE Years *55* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *S. C.*10 NAME OF FATHER *Corinthious Dace*11 BIRTHPLACE OF FATHER (city or town) (State or country) *S. C.*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *unknown*14 Informant (Address) *Elizabeth Hardey 116 N. Dallas St.*15 Filed *1928*Registra *R. H. H.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 15 1928*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 1928* to *March 10 1928*, that I last saw him alive on *March 14 1928*, and that death occurred, on the date stated above, at *6:45 P. M.*  
The CAUSE OF DEATH\* was as follows:*Lung Abscess (non-tubercular)*(duration) yrs. *2 mos* ds.CONTRIBUTORY (Secondary) *Toxemia. Chemical*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *no* Date of.Was there an autopsy? *no*What test confirmed diagnosis? *Physical & Laboratory*(Signed) *R. J. Young* M. D.19 (Address) *1429 E. Lombard St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Asbury Cemetery Mar. 18 1928*

UNDERTAKER

ADDRESS

*Chris. N. Johnson 46 N. Caroline St.*

E 31752

## HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

Sinar Hospital

CERTIFICATE OF DEATH.

REGISTERED NO.

E 31752

CITY OF BALTIMORE: (No.

2-FULL NAME

Jerome Leonard Brenner (Brenner)

ST.

WARD)

(a) RESIDENCE NO.

2312 Mondawmin Ave

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Jan 24 - 1919

AGE

Years

Months

Days

If LESS than 1 day, hrs or min

9

1

25

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Abraham Brenner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Pauline Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

Informant (Address)

Abraham Brenner

2312 Mondawmin Ave

Filed

18 1926

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/16 1928

17

I HEREBY CERTIFY, That I attended deceased from 3/11, 1928, to 3/16, 1928.

that I last saw him alive on 3/16, 1928

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH\* was as follows:

Endocarditis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Coronary Failure 20 ds.

18 Where was disease contracted if not at place of death?

(duration)

yrs.

mos.

ds.

2312 Mondawmin Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

H. J. Hanbury M. D.

1928 (Address)

Sinar Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hebrew Friendship Cem

3/18 1928

20 UNDERTAKER

Jack Lewis 1439 E BALTIMORE

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31753

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 E. Balt St ST. 3-4 WARD)

2-FULL NAME Mary Bodine

(a) RESIDENCE NO. 1405 E Balt St ST. 3-4 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX 7 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of or WIFE of Nathan Bodine

DATE OF BIRTH (month, day, and year) 3-30-1879

AGE Years 48 Months 11 Days 16 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Frank Eisman

11 BIRTHPLACE OF FATHER (city or town), (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Nathan Bodine (Address) 1405 E Balt St

R 18 1928 File 18 1928 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 19 28

17 I HEREBY CERTIFY, That I attended deceased from March 9 - 1928 to March 16 19 28, that I last saw her alive on March 16 19 28, and that death occurred, on the date stated above, at 11 P m. The CAUSE OF DEATH\* was as follows:

Bi-lateral Pneumonia (duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. Brown M. D. , 19 (Address) 126 S. D. St.

\*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hebrew Rosedale

3/18 19 28

20 UNDERTAKER

ADDRESS

J. Jack Lewis 1439 E. Balt St



E 31754

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31754

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Sinat Hospital 13-54 St. Ward)2-FULL NAME Fishel Cohen(a) RESIDENCE NO. 2341 Druid Hill Ave St. Ward(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Cohen6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
85

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Russia

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia12 MAIDEN NAME OF MOTHER Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

## 14

Informant Joe Cohen  
(Address) 2431 Druid Hill Ave

## 15

Filed 18 1928 18 1928 Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

inquiry and that said deceased came to his death on the day stated above.The CAUSE OF DEATH\* was as follows:  
Bronchopneumonia (Terminal)

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Accidental Fracture of (Secondary)Neck Left Femur (Signed) [Signature] M. D.

(Coroner)

3/18/28 (Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Removal 3/18 1928

20 UNDERTAKER

Jack Lewis

ADDRESS

1439 E. Balt. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31755

## CERTIFICATE OF DEATH.

90 E 31755

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3604 Clifton Ave. 15-61 WARD)2-FULL NAME Emma Heath

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3604 Clifton Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 89 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 7 1839AGE Years 89 Months 1 Days 9 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

18 1928

G. HANCOCK JONES, R. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 6, 1928, to Mar 16, 1928,that I last saw her alive on Mar-16-, 1928,and that death occurred, on the date stated above, at 3.40 A. M.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis, Senile, with myocardial insufficiency, and gradual failure (duration) 1 yrs. 10 mos. 10 ds.CONTRIBUTORY (Secondary) General Asthenia (duration) 1 yrs. 10 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical (Signed) Wesley Cole, M. D.(Address) 2702 Garrison Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Congressional Cem. Washington Mar 19 1928

UNDERTAKER

ADDRESS

Wm J. Beckner & Sons North Pa

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31756

## CERTIFICATE OF DEATH

51 E 31756

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1227 E. Hoffman St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Metz Jr.(a) RESIDENCE NO. 1227 E. Hoffman

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 3 mos. 12 ds.

How long in U. S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteSingle5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 4 1917

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..10312

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Attended

(b) General nature of industry, business, or establishment in which employed (or employer)

St. Paul's School

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

19 NAME OF FATHER

George J. Metz

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Marie A. Rotel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant

(Address)

Mr. George J. Metz  
1227 E. Hoffman

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928March 16

17

I HEREBY CERTIFY, That I attended deceased from

March 9 1928 March 16 1928that I last saw him alive on March 15 1928and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH\* was as follows:

Rheumatic Endocarditis  
(Mitral)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY  
(Secondary)Broncho-Pneumonia

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy?

What test confirmed diagnosis?

3/ (Signed)

7/28/28

(Address) 500 E. Madison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery, Ward 19

20 UNDERTAKER

ADDRESS

Henry Blackman 1501 E. Bay

APR 18 1928

H. J. JONES, R. D.

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31757

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

BALTIMORE CITY HOSPITAL ST. 18-76 WARD)

2-FULL NAME *William D. Green*(a) RESIDENCE No. *507 Calverton Ave* WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If non-resident give city or town and State)REGISTERED NO. *49*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *March 14 1866*AGE Years Months Days If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*62* *0* *2*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Ordnance*(b) General nature of industry, business, or establishment in which employed (or employer) *086*

(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) (State or country) *Ohio*10 NAME OF FATHER *Wm. D. Green*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *New Jersey*12 MAIDEN NAME OF MOTHER *Julia Wade*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Maryland*

Informant

(Address) *Records*

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *31 16 / 19 28*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 20, 1928, to Mar. 16, 1928.*that I last saw him live on *Mar. 16, 1928*and that death occurred, on the date stated above, at *7:30 P. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of pancreas*(duration) *1* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

if not at place of death? \_\_\_\_\_

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *yes*What test confirmed diagnosis? *General & Sub.*(Signed) *C. D. Holmes, M. D.*

, 19 \_\_\_\_\_ (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Prospect Hill Cemetery Mar. 18 1928*  
*Henry W. Mears & Son 805 N. Calverton*



E 31758

## HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 31758

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 N PulaskiST. 70-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Shadus B Crump(a) RESIDENCE NO. 513 N Pulaski

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. - mos.ST. - WARD -(If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 COLOR OR RACE white5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie S Crump6 DATE OF BIRTH (month, day, and year) 1853 July 47 AGE 74 Years 8 Months 7 Days 12

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Union(c) Name of employer United Railways9 BIRTHPLACE (city or town) (State or country) Petersburg Va10 NAME OF FATHER James R. Crump11 BIRTHPLACE OF FATHER (city or town) (State or country) Petersburg Va12 MAIDEN NAME OF MOTHER Mary Hanna13 BIRTHPLACE OF MOTHER (city or town) (State or country) Petersburg

14

Informant (Address) Irvin Crump  
673 N Pulaski St

15

Filed 8 1928

G. HARRISON JONES, M. D., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 22, 1928, to March 16, 1928, that I last saw him alive on March 14, 1928, and that death occurred, on the date stated above, at 2:05 A m. The CAUSE OF DEATH\* was as follows:Arteriosclerosis(duration) 2 yrs. 1 mos. - ds.CONTRIBUTORY (Secondary) Arteriosclerosis(duration) 1 yrs. 1 mos. - ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) W. H. M. D.3/16, 1928 (Address) 301 E. Green St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL London ParkDATE OF BURIAL March 19-2820 UNDERTAKER Bernard A. LinkADDRESS 734 Poplar Grove St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

2114156  
E 31759

E 31759

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

JOHNS HOPKINS HOSPITAL

ST. 7-9 WARD

## 2-FULL NAME

Bridget Richardson

## (a) RESIDENCE NO.

Sumter S. Carolina ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white

married

a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Wade Richardson

DATE OF BIRTH (month, day, and year)

Unknown

Age

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

42

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Sumter, S. C.

## 10 NAME OF FATHER

John Curran

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Sally Cobb

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Sumter  
South CarolinaInformant, Records  
(Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-17-1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 24, 1928, to March 17, 1928,

that I last saw her alive on March 17, 1928,

and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH\* was as follows:

Brain Tumor - Glioma  
(Benign) Right Hemisphere

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY  
(Secondary)Hemorrhage into the  
tumor

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? Yes Date of 3-7-28

Was there an autopsy? Yes

What test confirmed diagnosis?

Clinical, Operative &amp; Autopsy

(Signed)

F. D. Conner

M. D.

3-18-1928 (Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Sumter S. C.

UNDERTAKER

Wm. G. Cook

DATE OF BURIAL

3/18-1928

ADDRESS

502 E. North



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31761

## CERTIFICATE OF DEATH.

E 31761

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *606 Linco* St. *13-59* Ward)

Registered No. ....

## 2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *606 Linco*

St. ....

Ward ....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. ....

mos. ....

ds. ....

How long in U. S., if of foreign birth?

yrs. ....

mos. ....

ds. ....

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH.

3-SEX.

*91*

4-COLOR OR RACE,

*W*5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

5a-If married, widowed, or divorced

HUSBAND of (or) WIFE of

*John Owens*

6-DATE OF BIRTH (month, day and year)

*July 25, 1850*

7-AGE.

*77*

yrs. ....

mos. ....

ds. ....

If LESS than 1 day.

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

*At home*

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

## 9-BIRTHPLACE (city or town).

(State or Country).

*Balto Md*

10-NAME OF FATHER

*Edward McKellin*

11-BIRTHPLACE OF FATHER (city or town).

(State or Country).

*Md*

12-MAIDEN NAME OF MOTHER.

*Josephine Wolf*

13-BIRTHPLACE OF MOTHER (city or town).

(State or Country).

*Md*

14-

(Institution)

(Address)

*Margaret M. Walker*  
*606 Linco St*

16-DATE OF DEATH (month, day and year).

*3-17-28*

17-

I HEREBY CERTIFY, That I attended deceased from

*Nov 10*19*27*

to

*Mar 17*19*28*

that I last saw him alive on

*Mar 16*19*28*and that death occurred, on the date stated above, at *5:30 A. m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach & liver*

(Duration)

yrs. *10*mos. *7*

ds. ....

CONTRIBUTORY

(Secondary)

*Exhaustion*

(Duration)

yrs. ....

mos. *7*

ds. ....

18-Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*W. H. Robert Keetch**Mar 17, 1928*(Address) *2502 Colburn 113th*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL

*London Park**3/20 1928*

20-DECEASED

ADDRESS

*W. H. Robert Keetch**502 E. North Ave*

MAR 18 1928

J. H. Jones, Jr. Registrar.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31762

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2847 St. Landoale St. 16-68 WARD)2-FULL NAME Anna Muriel Heingerling(a) RESIDENCE NO. 2847 St. Landoale St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced HUSBAND of (or) WIFE of George HeingerlingDATE OF BIRTH (month, day, and year) Aug 16, 1884AGE Years Months Days If LESS than 1 day, hrs. or min.  
43 7 0

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.10 NAME OF FATHER John J. Dobbin11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore12 MAIDEN NAME OF MOTHER Caroline Cereghy13 BIRTHPLACE OF MOTHER (city or town) (State or country) BaltimoreInformant (Address) Viola Bauer  
8 Ridgeway Rd. - Catonsville

Filed

AR 18 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 10, 1928, to Mar 16, 1928, that I last saw him alive on Mar 16, 1928, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Pulver Pneumonia(duration) yrs. mos. ds. 6

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical signs(Signed) J. E. Heider M. D.Mar 1928 (Address) 1301 N. Park St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
Funeral

DATE OF BURIAL

3/20 1928

ADDRESS

5825 N. Park St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31763

## CERTIFICATE OF DEATH.

90 E 31763

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore City Hospital*)ST. *W* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Chas Lucas*(a) RESIDENCE NO. *22 E. North St.*

(Usual place of abode)

ST. *E* WARDLength of residence in city or town where death occurred *Life* yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced HUSBAND of (or) WIFE of *Kate Lucas*DATE OF BIRTH (month, day, and year) *1860*AGE Years Months Days If LESS than 1 day, hrs or min. *68*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. *Penman*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Baltimore, Md.*10 NAME OF FATHER *Joseph Lucas*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Marcela P.*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*Informant (Address) *Flora Harris 348 E. North St.*Filed *17 1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from *1-3*, 19*28*, to *Mar 16*, 19*28*, that I last saw him alive on *Mar 16*, 19*28*, and that death occurred, on the date stated above, at *2:15 P.* m.

The CAUSE OF DEATH\* was as follows:

*Ch. Myocardite  
Impaired heart function  
Generalized arteriosclerosis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *3*18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Chemical*(Signed) *J. M. Cook* M. D., 19 (Address) *Baltimore City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Lorraine*

DATE OF BURIAL

*3/20 1928*20 UNDERTAKER *J. M. Cook*ADDRESS *302 E. North St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31764

## CERTIFICATE OF DEATH.

74-001  
E 31764  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 St. Wolfe ST. 8-17 WARD)2-FULL NAME Anna M. Hanna(a) RESIDENCE NO. 1701 St. Wolfe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Mrs. R. HannaDATE OF BIRTH (month, day, and year) May 27, 1868AGE Years 59 Months 9 Days 18 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Germany  
(State or country)10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)Informant Mrs. R. Hanna  
(Address) 1701 St. Wolfe St.Filed 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-15-192817 I HEREBY CERTIFY, That I attended deceased from March 4, 1928 to March 15, 1928,  
that I last saw him alive on March 15, 1928,  
and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH\* was as follows:

Coronary thrombosisCONTRIBUTORY  
(Secondary)(duration) yrs. mos. ds. 11(duration) yrs. mos. ds. 818 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signature)

1978 (Address) 1501 E. Ely, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm Cook502 E. Veto

## E 31765 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital* ST. *17-24* WARD)

## 2. FULL NAME

*John Sadler*  
*722 Dolphin*

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

ST. WARD

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Male**Col.**Married*6 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Frances Sadler*

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*50*

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Laborer* *040*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*United Railways*

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*North Carolina*

10 NAME OF FATHER

*Wm Sadler*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*N.C.*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*Informant  
(Address)*Frances Sadler*  
*722 Dolphin*

MAR 18 1928

Registrar

E 31765

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/16/1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*3/5/28*, 19 *28*, to *3/16*, 19 *28*,  
that I last saw him alive on *3/16*, 19 *28*,and that death occurred, on the date stated above, at *1:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Appendicial abscess*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?*Home*

Did an operation precede death? Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

(Signed)

*H. Lawrence Zahm, M.D.*

, 19

(Address)

*St Joseph Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVES

20 UNDERTAKER

*Charlotte N.C.*  
*Samuel H. Hensley*

DATE OF BURIAL

*3/18/28*

ADDRESS

*178*



## E 31766 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11-25 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Healer Chatman

(a) RESIDENCE NO.

5-14 Dyson

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

Black

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

7-8-27

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.788

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Ind -

10 NAME OF FATHER

Geo Chatman11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Ind -

12 MAIDEN NAME OF MOTHER

Elsie Thomas13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)IndInformant  
(Address)Records -

Filed

18 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 4, 1928, to Mar. 16, 1928.that I last saw her alive on Mar. 16, 1928.and that death occurred, on the date stated above, at 8 a- m.

The CAUSE OF DEATH\* was as follows:

Diffuse lobular pneumonia, probably  
tuberculous.(duration) yrs. 3 mos. 12 ds.CONTRIBUTORY Bilateral white matter  
(Secondary)(duration) yrs. mos. 14 ds.18 Where was disease contracted  
if not at place of death?HomeDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Ray

(Signed)

M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DERTAKER

DATE OF BURIAL

3/18/28

ADDRESS

Sumner Hensley

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31767

## CERTIFICATE OF DEATH.

129 E 31767

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 N. Monroe ST. 15-71 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs. 11 mos.

ds. How long in U. S., if of foreign birth?

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Augustin Miller

7 DATE OF BIRTH (month, day, and year) April 16, 1852

8 AGE Years 75 Months 11 Days 10 If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Anna Halland 1904 N. Monroe St

15 Filed 8-19-28

16 HANDED ON JUNE 1, 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1928

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1927, to March 16, 1928, that I last saw her alive on March 16, 1928, and that death occurred, on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

CONTRIBUTORY (duration) 6 yrs. 6 mos. ds. Chronic Interstitial Nephritis

(Secondary) (duration) One yr. 8 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical &amp; Microscopic (Signed) W. J. Sullivan M. D.

3/17, 1928 (Address) 1701 N. Fulton Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral

March 19, 1928

20 UNDERTAKER

Martin P. Hayes &amp; Sons

1527 N. North

## HEALTH DEPARTMENT-CITY OF BALTIMORE

E 31768

## CERTIFICATE OF DEATH

129 E 31768

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *4-7* Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Miss Mary Conroy*(a) RESIDENCE NO. *Frostburg, Md* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *7* yrs. *7* mos. *7* ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female* *white* *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Dr. Timothy L. Conroy*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

14

Informant (Address)

15 Filed

18 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

*3/11/28*, 19\_\_\_\_, to *3/17/28*, 19\_\_\_\_,that I last saw *h&x* alive on *3/17/28*, 19\_\_\_\_,and that death occurred, on the date stated above, at *4:22* m.

The CAUSE OF DEATH\* was as follows:

*Chronic nephritis*(duration) *9 months* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Broncho pneumonia*(duration) \_\_\_\_ yrs. \_\_\_\_ mos. *5* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_

Was there an autopsy? \_\_\_\_

What test confirmed diagnosis?

(Signed) *J. S. Windland*, M. D., 19\_\_\_\_ (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

*Chas. J. Rawdon 1181 Mt. Royal Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31769

## CERTIFICATE OF DEATH.

90

E 31769

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Yale Ave

ST. 20-21 WARD)

2-FULL NAME Susie P. Hayes

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 411 Yale Ave.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 9 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

1850

6 DATE OF BIRTH (month, day, and year) Mar 26 th 1855

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

77

11

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland  
(State or country)

10 NAME OF FATHER John Hays

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosanna Cole

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Maryland

14

Informant Joel Hays  
(Address) 411 Yale Ave

15

Filed

19

S. J. JONES, K. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Jan - 1 - , 1927, to March , 1928;  
that I last saw her alive on March , 1928;

and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Lloyd Johnson, M. D.

, 19 (Address) Frederick &amp; Augusta

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Pine Grove Cem

Mar 19, 1928

20 UNDERTAKER

ADDRESS

E. LEROY STIFFLER

125 E. North Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31770

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *W. M. Mary Hochel* ST. *1-1* WARD *1-1*)

2-FULL NAME Hall, George

(a) RESIDENCE NO. 528 St Marys St. ST., WARD \_\_\_\_\_  
(Usual place of abode)  
length of residence in city or town where death occurred 38 yrs. 7 mos. 13 ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
4	Black	Married

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)				1899
AGE	Years	Months	Days	IF LESS than 1 day, .... hrs or .... min.
38	38	7	13	

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Seaman Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) *Seaman*

(c) Name of employer St. James Weems

BIRTHPLACE (city or town) Baets, Md.  
(State or country)

10 NAME OF FATHER *William E Hall*

11 BIRTHPLACE OF FATHER (city or town) Philadelphia  
(State or country)

12 MAIDEN NAME OF MOTHER *Lynn Fletcher*

13 BIRTHPLACE OF MOTHER (city or town) Prine, L. C. Mo  
(State or country) Mo

Informant Records W. L. Martin, Jr.  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-17 1928

17 I HEREBY CERTIFY, That I attended deceased from 3-13, 1928, to 3-17, 1928, that I last saw him alive on 3-17, 1928, and that death occurred, on the date stated above, at 2<sup>45</sup> P. M.

CONTRIBUTORY  
(Secondary)

18 Where was disease contracted  
if not at place of death?..... *Baltimore Md*

Did an operation precede death? No Date of

**Was there an autopsy?**

What test confirmed diagnosis? *Laboratory exam of sputum*  
(Signed) *A. Spencer* M. D.

, 19 (Address) W. L. Marine Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

Filed \_\_\_\_\_ 19\_\_\_\_

## Register

## HEALTH DEPARTMENT—CITY OF BALTIMORE

211833  
631771

## CERTIFICATE OF DEATH.

129 E 31771

## 1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.)

ST. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Theresa Kendall

(a) RESIDENCE NO.

426 N. Bradford

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Life yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female

white

married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

John Kendall

DATE OF BIRTH (month, day, and year)

Oct-13-1889

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

38

5

2

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Md

10 NAME OF FATHER

Frank Matochek

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Bohemia

Informant  
(Address)

Records

Filed

1928

HARRISON JONES, E. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 16 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 6, 1928, to Mar 15, 1928,

that I last saw her alive on Mar 6, 1928,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home - Baltimore

Did an operation precede death? Yes Date of 3-14-28

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. S. Wham, M. D.

3-16-1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak Hill Cemetery

Mar. 19 1928

20 UNDERTAKER

ADDRESS

Mrs. C. Miller &amp; Son

2334 Jefferson St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31772

J-PLACE OF DEATH

## CERTIFICATE OF DEATH.

78 E 31772

CITY OF BALTIMORE: (No. *Wt Hope Retreat* ST. *2863* WARD)2-FULL NAME *Alfred Grillo Biagio Grillo*(a) RESIDENCE NO. *Wt Hope Retreat*

(Usual place of abode)

Length of residence in city or town where death occurred *Unknown* mos.ST. *2863* WARD *18*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

6a If married, widowed, or divorced

HUSBAND of *Unknown*

(or) WIFE of

7 DATE OF BIRTH (month, day, and year) *Feb, 1884*

8 AGE

*44* YearsMonths *1*Days *21*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

*As Laborer*

(c) Name of employer

*None*

9 BIRTHPLACE (city or town) (State or country)

*Italy*10 NAME OF FATHER *Antonio Grillo*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Italy*12 MAIDEN NAME OF MOTHER *Rita Grillo*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Italy*

4

Informant *Wt Hope Retreat Records* (Address)

5

File *1928**C. H. JONES, Jr.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 16, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Sept 1, 1926* to *March 16, 1928*.that I last saw him alive on *March 15, 1928*.and that death occurred, on the date stated above, at *1:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Epileptic Convulsions & Exhaustion*(duration) *3* yrs. *3* mos. *3* ds.

CONTRIBUTORY (Secondary)

*Leumal, Parents Prone*(duration) *5* yrs. *—* mos. *—* ds.18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chemical Study*(Signed) *C. D. Enzor* M. D.

7-16 1928 (Address)

*Wt Hope Retreat*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*St Vincent Cemetery*

DATE OF BURIAL

*31 18 1928*

ADDRESS

*George J. Ruth 1735 Harford Ave.*

**E 31773**

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**E 31773**

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 636 Mc Kuen Ave 946 Ward)2-FULL NAME Lans. C. Clark. Jr.(a) RESIDENCE NO. 636 Mc Kuen Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)MaleWhiteSingle6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

Lans. C. Clark.636 Mc Kuen Ave15 Filed 1928

C. HARRISON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from  
March 14, 1928, to March 15, 1928that I last saw him alive on March 15, 1928and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH\* was as follows:

Bronch - Pneumonia(duration) ..... yrs. .... mos. 3 ds.

CONTRIBUTORY

(Secondary)

Unknown

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death?..... Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

16, 19

28

Address

14

50

14

50

14

50

14

50

14

50

14

50

14

50

14

50

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Holy Redeem ChurchMarch 19, 1928

20 UNDERTAKER

ADDRESS

George J. Puth735Hospital735Hospital735Hospital735Hospital735



E 31774

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 31774

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1324) Ward 23-31

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Lewis, Lanterbach

## (a) Residence No.

(Usual place of abode)

1324 Hanover St.

Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

64 yrs. 11 mos. 13 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

## 5-Single, Married, Widowed, or Divorced

Married (Write the words)

## 5a-If married, widowed, or divorced

HUSBAND of (or) WIFE of

Margaret A. Lanterbach

## 6-DATE OF BIRTH (month, day and year)

April 4<sup>th</sup> 1863

## 7-AGE

64 yrs. 11 mos. 13 ds.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Lino Blower

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9-BIRTHPLACE (city or town)

(State or Country)

Baltimore, Md.

PARENTS:

## 10-NAME OF FATHER

John Lanterbach

## 11-BIRTHPLACE OF FATHER (city or town)

(State or Country)

Germany

## 12-MAIDEN NAME OF MOTHER

Bertha Schmidt

## 13-BIRTHPLACE OF MOTHER (city or town)

(State or Country)

Germany

## 11-

(Informant)

Margaret A. Lanterbach

(Address)

1324 Hanover St.

19 1928

Filed

G. H. JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH (month, day and year)

3/16/28

## 17-

I HEREBY CERTIFY, That I attended deceased from

March 12, 1928, to March 16, 1928,

that I last saw him alive on March 16, 1928,

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(Duration) 7 yrs. 4 mos. 4 ds.

## CONTRIBUTORY

(Secondary)

## 18-Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19-PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

London Park Cem

March 19, 1928

## 20-UNDERTAKER

## ADDRESS

Schloman Bros

1029

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31775

## CERTIFICATE OF DEATH.

E 31775

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 205 S Register St. 2-4 Ward)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male white

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MOTHER'S NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)

## 15 Filed

R 19 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17

I HEREBY CERTIFY That I took charge of the

remains described above, held an...  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained to said...  
(Inquest, autopsy or inquiry.)

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* is as follows:

Cap. Bronchitis

CONTRIBUTORY  
(Secondary)

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

(duration).....yrs.....mos.....ds.

V-61

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31776

## CERTIFICATE OF DEATH.

E 31776

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3308 Ellerslie Ave. ST., 9-46 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME Emma Hayden Alexander

(a) RESIDENCE No. 3310 Ellerslie Ave. ST., WARD Resident  
(Usual place of abode)  
Length of residence in city or town where death occurred 46 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? 46 yrs. 10 mos. 2 ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of George Clayton Alexander

DATE OF BIRTH (month, day, and year) May-15-1881

AGE Years Months Days If LESS than 1 day, hrs. or min.  
46 10 2

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Eberhard Hayden

11 BIRTHPLACE OF FATHER (city or town) Oldenburg (State or country) Germany

12 MAIDEN NAME OF MOTHER Jane Paddington

13 BIRTHPLACE OF MOTHER (city or town) Isle of Man (State or country) West Indies

Informant Mr. George C. Alexander (husband) (Address) 3310 Ellerslie Ave.

Filed

MAR 19 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pistol Shot Wound in Brain

Suicide

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) J. H. Butcher M. D.

Mar 18/28 (Address) 508 E. Ninth Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death - yrs. - mos. - ds. In the State 46 yrs. 10 mos. 2 ds.

Where was disease contracted, if not at place of death?

3308 Ellerslie Ave  
Former or usual residence 3310 Ellerslie Ave

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cemetery

## DATE OF BURIAL

Mar-18-28

## ADDRESS

103 W. NORTH AVE.

20 UNDERTAKER STEWART &amp; KOWEN COMPANY (WILLIAM F. WOODBET, Successor)

E 31777

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4101 Groveland Ave.* ST. *28-63* WARD *28*)2-FULL NAME *Matilda Kate Wilson*(a) RESIDENCE NO. *4101 Groveland Ave.* 27 WARD *Resident*

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. *?* mos. *?* ds.How long in U. S., If of foreign birth? *70* yrs. *4* mos. *5* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *Female White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*a- If married, widowed, or divorced, HUSBAND of (or) WIFE of *Single*DATE OF BIRTH (month, day, and year) *Nov-11-1857*AGE Years Months Days If LESS than 1 day, hrs or min. *70* *4* *5*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *none*(c) Name of employer *none*BIRTHPLACE (city or town) (State or country) *Accomac Co. Virginia*10 NAME OF FATHER *Boyd F. J. Wilson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Northampton Virginia*12 MAIDEN NAME OF MOTHER *Amanda Robins*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Northampton Virginia*Informant (Address) *Mrs Stanley Cowman (Friend)*

MAR 19 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/16-* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *Mar-8*, 19 *28*, to *Mar 16-*, 19 *28*, that I last saw *her* alive on *Mar 15*, 19 *28*and that death occurred, on the date stated above, at *4 9* m.

The CAUSE OF DEATH\* was as follows:

*Brucella Sanguinaria*CONTRIBUTORY (duration) yrs. mos. *9* ds. *Heart Failure*  
(Secondary) (duration) yrs. mos. *3* ds. *gradual*18 Where was disease contracted if not at place of death? *—*Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*  
(Signed) *Stanley Cowman*, M. D.2/16/1928 (Address) *2207 Gorman*  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

FUNERAL UNDERTAKER

ADDRESS

*Louison Park Cemetery* *Mar 19 1928*  
*Stewart Monro Co. - Balto.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31778

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2037 Cliftwood* ST. *8* WARD)2. FULL NAME *Mary E Sewell*(a) RESIDENCE NO. *2037 Cliftwood* ST. *8* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *17* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? *17* yrs. *0* mos. *0* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 31778

## PERSONAL AND STATISTICAL PARTICULARS

SEX *M*4 COLOR OR RACE *N*5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced HUSBAND of (or) WIFE of *Thomas H Sewell*DATE OF BIRTH (month, day, and year) *Mar 6, 1860*

AGE

Years *68*Months *0*Days *11*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *MD*10 NAME OF FATHER *Abell Elliott*11 BIRTHPLACE OF FATHER (city or town) (State or country) *MD*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *MD*Informant *Eva Cushman*(Address) *2037 Cliftwood St*Filed *1928*Registrar *W. H. Cook*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 17, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 9, 1928*, to *Mar 17, 1928*, that I last saw her alive on *Mar 17, 1928*, and that death occurred, on the date stated above, at *5:00 P. M.* The CAUSE OF DEATH\* was as follows:*Central pneumonia*CONTRIBUTORY (Secondary) *Pulmonary edema* (duration) *1* yrs. *1* mos. *1* ds.18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *Specimen*(Signed) *J. B. Smith*

M. D.

3/19/28 (Address) *302 East Street*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Bromes Island MD*DATE OF BURIAL *Mar 20, 1928*UNDERTAKER *W. H. Cook*ADDRESS *502 E North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31779

## CERTIFICATE OF DEATH.

E 31779

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2805 Alameda Blvd ST. 9-46 WARD)

## 2-FULL NAME Mary B. Lipka

(a) RESIDENCE NO. 2805 Alameda Blvd ST. 9-46 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds.

Now long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles B. Lipka

DATE OF BIRTH (month, day, and year) Dec 4, 1842

AGE

Years 85

Months 3

Days 13

If LESS than 1 day. hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Mrs Elizabeth Smith 2805 Alameda Blvd

Filed 1928

Per Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 24, 1928, to Mar 16, 1928, that I last saw deceased on Mar 15, 1928, and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH\* was as follows:

Pneumonia Hypostatic

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Gorm M. D. 3/17, 1928 (Address) 600 N. Main St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St Vincent

UNDERTAKER J. M. Cook

ADDRESS 502 E. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31780

## CERTIFICATE OF DEATH.

E 31780

## 1-PLACE OF DEATH

CITY OF BALTIMORE: /No. 3438 Elmley Ave.

## 2-FULL NAME William T. Houghton

(a) RESIDENCE NO. 3438 Elmley Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD Eastern Shore Md.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced

HUSBAND or WIFE

Ellen Houghton

DATE OF BIRTH (month, day, and year) Oct 18, 1859

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

4

29

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

BIRTHPLACE (city or town) (State or country)

England

10 NAME OF FATHER

Samuel Houghton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

Muhmm

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

Informant (Address)

Mrs. Florence Middleton 3438 Elmley Ave.

Filed

1928

MAR 20

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 14, 1928, to March 17, 1928,

that I last saw him alive on March 17, 1928,

and that death occurred, on the date stated above, at 845 P. M.

The CAUSE OF DEATH\* was as follows:

Heart disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Red blood albumen

(Signed) H. J. H. M. D.

(Address) 1618 Jones St. W.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

DATE OF BURIAL

Mt. Olivet

Mar 20, 1928

20 UNDERTAKER

ADDRESS

J. M. Cook

302 E. North Ave.

E 31781

## HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 31781

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 S. Clinton

2-FULL NAME Dorothy Marie Scheuerman

(a) RESIDENCE No. 1103 S. Clinton

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 1 WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 31, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

1

18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER Robert Scheuerman

11 BIRTHPLACE OF FATHER (city or town) Balto.  
(State or country)

12 MAIDEN NAME OF MOTHER Marie Keibler

13 BIRTHPLACE OF MOTHER (city or town) Balto.  
(State or country)14 Informant Elizabeth Keibler  
(Address) 1103 S. Clinton St.

15 Filed 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 19 28

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1928, to March 18, 19 28.

that I last saw her alive on March 18, 19 28.

and that death occurred, on the date stated above, at 1.0 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY Myocardial Insuf.  
(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas M. D.

3-18-28 (Address) 3037 O'Donnell St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL  
MOVALSt. Pauls Cemetery March 19 28  
UNDERTAKER ADDRESS

William C. 5026 North



31782

## HEALTH DEPARTMENT—CITY OF BALTIMORE—E 31782

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore* WARD)

## 2-FULL NAME

*Anna Lovell*

## (a) RESIDENCE NO.

*176 S. Boulder St.*

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced. (write the word)

*Married*

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Christopher J. Lovell*

DATE OF BIRTH (month, day, and year)

*1866*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*62*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

*Baltimore Md*

## 10 NAME OF FATHER

*Fredrich Loewenstein*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

## 12 MAIDEN NAME OF MOTHER

*Mary Bailey*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

Informant

(Address)

*Fredrich J. Lovell  
249 S. Highland Ave*Filed *13* 1928

HARRISON JONES, K.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-19 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*3-15 1928*, to *3-19 1928*that I last saw *her* alive on *3-19 1928*and that death occurred, on the date stated above, at *1245* m.

The CAUSE OF DEATH\* was as follows:

*Intestinal Obstruction  
Chronic Hepatitis  
Exhaustion*(duration) *Chronic*

## CONTRIBUTORY

(Secondary)

*Alcohol Poisoning*(duration) yrs. mos. *3* ds.

## 18 Where was disease contracted

if not at place of death?

*Home*Did an operation precede death? *yes* Date of *3-15-28*Was there an autopsy? *no*

What test confirmed diagnosis?

*Operation*

(Signed)

*Blagovest* M. D.

, 19

(Address)

*Baltimore*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

*Oak Lawn**3/23 1928*

## 20 UNDERTAKER

## ADDRESS

*Wm Cook**512 E. North Ave*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31784

## CERTIFICATE OF DEATH.

31 E 31784

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2572 Edmondson Ave. ST. 16-69 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. J. Tyrrell Hennessy,

(a) RESIDENCE NO. 2572 Edmondson Ave.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene C. Hennessy,

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1891

7 AGE Years 36 Months 3 Days 8 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician,

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) Syracuse New York (State or country)

10 NAME OF FATHER John Hennessy,

11 BIRTHPLACE OF FATHER (city or town) Syracuse N.Y. (State or country)

12 MAIDEN NAME OF MOTHER Nellie Tyrrell,

13 BIRTHPLACE OF MOTHER (city or town) Syracuse N.Y. (State or country)

14 Informant Mrs. Irene C. Hennessy (Address) 2572 Edmondson Ave.

15 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 17 1928

17 I HEREBY CERTIFY, That I attended deceased from February 12- 1928 to March 17- 1928, that I last saw him alive on March 16- 1928, and that death occurred, on the date stated above, at 4:40 a. m.

The CAUSE OF DEATH\* was as follows:

Tubercular Meningitis

(duration) - yrs. - mos 14 ds.

CONTRIBUTORY Pulmonary Tuberculosis (Secondary)

(duration) 2 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? physical signs - symptoms (Signell) Chester Piland, M. D.

3-17-1928 (Address) 2532 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31785

## CERTIFICATE OF DEATH.

E 31785  
REGISTERED NO.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *911 N. Charles* WARD) *11-15*2. FULL NAME *Mary Ann Dorritie*(a) RESIDENCE NO. *911 N. Charles* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *52* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced

(or) WIFE of *A. L. Dorritie*6 DATE OF BIRTH (month, day, and year) *Sept 30 1876*

7 AGE

Years *51*Months *6*Days *16*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *City*10 NAME OF FATHER *Henry Herbes*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Ann M. Frank*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *German*

14

Informant (Address) *Bingie J. Herbes*

15

Filed *9 13 20*

16

C. H. JONES, R. J.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/15/ 1928*

17

I HEREBY CERTIFY, That I attended deceased from *JANUARY 1<sup>st</sup>, 1928* to *MARCH 16<sup>th</sup>, 1928*. that I last saw her alive on *March 16<sup>th</sup>, 1928*.and that death occurred, on the date stated above, at *9<sup>30</sup>* A. M.

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*CONTRIBUTORY (Secondary) *about* (duration) *2* yrs. mos. ds. *Influenced with asthma* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Thomas L. Shearer* M. D.MAR 24 1928 (Address) *905 N. Charles St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*buried at the old cem**3/19/ 1928*

UNDERTAKER

*J. J. Moran**E. B. Batty*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31786

## CERTIFICATE OF DEATH.

E 31786

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4721 Harford Ave. St. 27-44 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Airey

(a) RESIDENCE NO. 4721 Harford Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Thomas A. Airey

6 DATE OF BIRTH (month, day, and year)

Jan. 22, 1859,

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

69

1

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Penna.

10 NAME OF FATHER

Samuel Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Penna.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

(Address)

Thomas A. Airey

4721 Harford Ave.

15

Filed

MAR 10 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 16 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 9 to Mar 16, 1928, to Mar 16, 1928.

that I last saw him alive on Mar 16, 1928.

and that death occurred, on the date stated above, at 11:00 p.m.

The CAUSE OF DEATH\* was as follows:

Exhaustion &amp; 7 exams.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Refutation

(Signed) Charles D. Miller M. D.

(Address) 4721 Harford Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Green Mount Cem. Mar 19 1928

20 UNDERTAKER

ADDRESS

Mrs. Albert E. Haller 4806 Harford Ave.

31787

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Md General Hospital

REGISTERED

31787

City of BALTIMORE: (No. 101-001)

Madison &amp; Linden St. 10th Ward

2-FULL NAME

Samuel Henderson

(a) RESIDENCE NO.

Westminster Md 2nd Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. 3 ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

9-22-24

7 AGE

Years

3

Months

6

Days

4

IF LESS than 1 day hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

Child

(c) Name of employer

Child

9 BIRTHPLACE (city or town)

(State or country)

Westminster Md

10 NAME OF FATHER

Harry Henderson

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Carroll Co Md

12 MAIDEN NAME OF MOTHER

Alice Lippo

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Carroll Co Md

14

Informant (Address)

Hospital Record

15 Filed 1928

C. HARRISON JONES, R.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-18-28

17

I HEREBY CERTIFY, That I attended deceased from

3-16-28 to 3-18-28

that I last saw him alive on

3-18-28

and that death occurred, on the date stated above, at

7:30 P.M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration)

yrs. mos. 10 ds.

CONTRIBUTORY

Lobar Pneumonia

(Secondary)

Chronic Cardiac Disease

(duration)

yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Carroll Co Md

Did an operation precede death?

No Date of

Was there an autopsy?

None

What test confirmed diagnosis?

Criminal Justice

(Signed)

19

(Address)

No. 101 Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Leister Church - Carroll Co

3-21-28

20 UNDERTAKER

Edw. Chilton

ADDRESS

Hampstead Md

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31788

## CERTIFICATE OF DEATH.

E 31788

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8-17 ST. WARD)2-FULL NAME William S. Johnson(a) RESIDENCE NO. 2017 E-North ST. ONE WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Josephine6 DATE OF BIRTH (month, day, and year) Nov 4 18617 AGE Years Months Days If LESS than 1 day, hrs. or min.  
66 4 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland  
(State or country)10 NAME OF FATHER George Johnson11 BIRTHPLACE OF FATHER (city or town) Md -  
(State or country)12 MAIDEN NAME OF MOTHER Eloj Shalley13 BIRTHPLACE OF MOTHER (city or town) Md  
(State or country)14 Informant Records -  
(Address)15 FILED AR 19 1928 JOHNSON, W. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 192817 I HEREBY CERTIFY, That I attended deceased from March 15 1928 to March 17 1928, that I last saw him alive on March 17 1928, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH\* was as follows:

Atherosclerosis Embolism  
Coronary Arteriosclerosis Myocardial  
Insufficiency Angina Pectoris  
(duration) yrs. 8 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death? at homeDid an operation precede death? No. Date ofWas there an autopsy? yes.What test confirmed diagnosis? autopsy(Signed) Lyman M. Jones, M. D.8 1, 19 (Address) Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Olivet Cem.Mar 19, 28

UNDERTAKER

ADDRESS

Wm. Hecker SonsNorth Pa

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31789

## CERTIFICATE OF DEATH.

100-E 31789

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 1-3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Shirley Holland

## (a) RESIDENCE NO.

2222 East Lombard St.

(Usual place of abode)

## WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Bald

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## DATE OF BIRTH (month, day, and year)

8-14-27

## AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

7 Months

1

3

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Ind

## 10 NAME OF FATHER

Elmer Holland

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ind

## 12 MAIDEN NAME OF MOTHER

Josephine Dougherty

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ind

Informant  
(Address)

Records

Filed

1928

JOHN JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar-17 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar-7 1928, to Mar-17 1928,

that I last saw her alive on March 17 1928,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia, both lungs

(duration) yrs. mos. 18 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

At Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy &amp; phys. exam

(Signed) Lyman M. Jones, M. D.

2-17, 1928 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

McCormick Cemetery

UNDERTAKER

John Ulrick

## DATE OF BURIAL

Mar 19, 1928

## ADDRESS

2208  
Belmont



31790

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129E 31790  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (In *West Baltimore General Hosp*)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Joac E. Becker*

## (a) RESIDENCE NO

*2734 Linden Ave*

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

*4* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

*1895*

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.*33*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Gardmaster. R.P.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Canton R.P. Co.*BIRTHPLACE (city or town)  
(State or country)*Dubuois, Iowa*

10 NAME OF FATHER

*Israel Becker*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Russia*

12 MAIDEN NAME OF MOTHER

*Rose Krone*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Russia*Informant  
(Address)*Jack Lewis  
1439 E. Baltimore*

Filed

1928

C. HARRISON JONES, R. L. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 18 1928*

17

I HEREBY CERTIFY, that I attended deceased from

*Mar 8, 1928, to Mar 18, 1928*that I last saw him live on *Mar 18, 1928*and that death occurred, on the date stated above, at *10:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial  
Nephritis*(duration) *2(?)* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Louis F. Levy*, M. D.(Address) *W. Baltimore Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Hebrew Int. Cemetery**3/19 1928*

UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Baltimore*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31791

## CERTIFICATE OF DEATH.

E 31791

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3927 Fair Ave*)ST. *26-37* WARD2-FULL NAME *A. Katherine Poulsen*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. *3927 Fair Ave*

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred *53* yrs. mos.How long in U. S., if of foreign birth? *53* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Paul Poulsen*DATE OF BIRTH (month, day, and year) *June 12-1888*AGE Years *59* Months *9* Days *6* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Germany*10 NAME OF FATHER *John G. Weaver*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*12 MAIDEN NAME OF MOTHER *Elizabeth Lehr*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

Informant

(Address)

*Paul Poulsen*  
*3927 Fair Ave*

Filed

1928 C. HAZARD JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 18 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 3 1928* to *March 16 1928*.that I last saw her alive on *March 16 1928*.and that death occurred, on the date stated above, at *4 A* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Failure*  
*General Carcinomatosis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *2-4-28*Was there an autopsy? *No*What test confirmed diagnosis? *Path. exam*

(Signed)

*W. H. H. M. D.*, 19 (Address) *1711 E. Egan Pl.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Oaklawn Cemetery*

DATE OF BURIAL

*3/21 1928*

ADDRESS

*1737 E. Egan*

20 UNDERTAKER

*George W. Girkler*

E 31792

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31792

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Hanover St.

ST. 24-34 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna B. Deems

(a) RESIDENCE NO. 1621 Marshall St

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of  
Unknown

DATE OF BIRTH (month, day, and year) Nov. 11 1882

AGE	Years	Months	Days	If LESS than 1 day. hrs or min
	45	4	6	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER John Rossiter

11 BIRTHPLACE OF FATHER (city or town) Ger.  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)Informant Mrs. Imhoff  
(Address) 1618 Hanover St

R 19 1928 HANSON JONES, K. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 1 1928, to Mar 17 1928  
that I last saw h alive on Mar 17 1928  
and that death occurred, on the date stated above, at 11 H m.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute dilatation of heart 2 ds.  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. E. Campbell M. D.

18, 1928 (Address) 1644 Hanover St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill Cem

DATE OF BURIAL

Mar 20 1928  
ADDRESS

UNDERTAKER

J. F. McCall

130 E. Fort

E 31793

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31793

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3523 Gough

ST. 26-37 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Olivia Piedro Gaecomo

(a) RESIDENCE NO. 3523 Gough

(Usual place of abode)

ST. 26 WARD

Length of residence in city or town where death occurred

yrs. 5 mos. 24 ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 23, 1927

AGE Years Months Days If LESS than 1 day, hrs. or min.  
5 24

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER Anzelmo Gaecoma

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Italy

12 MAIDEN NAME OF MOTHER Annie DeProspari

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) ItalyInformant Anzelmo Gaecomo  
(Address) 3523 Gough St

Filed: 1928 ( ) H. K. K. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1928

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1928, to March 18, 1928,

that I last saw her alive on March 18, 1928, and that death occurred, on the date stated above, at 6:12 A. m.

The CAUSE OF DEATH\* was as follows:

Whooping Cough

(duration) yrs. mos. 14 ds.

CONTRIBUTORY Brochial Pneumonia  
(Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cavallaro, M. D.

19 (Address) 214 Fuller St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

St. Stanislaus Sem. Mar. 19, 1928

UNDERTAKER

ADDRESS

Lilly &amp; Zeller Inc. 403 S. Wolfe St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31794

## CERTIFICATE OF DEATH.

57 E 31794

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Baltimore General Hospital*)

## 2-FULL NAME

*Hester E. Murphy*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

*1018 N. Wolfe*

ST.

WARD

Length of residence in city or town where death occurred

*20* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Female*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*April 26, 1884*

AGE

Years

*43*

Months

*10*

Days

*20*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Sam Conway*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Clivia Deshield*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Maryland*

Informant

(Address)

*Louise Murphy*  
*1218 N. Wolfe*

Filed 1928

19

RANKIN JONES, R. 3

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 16, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 14, 1928*, to*Mar 16, 1928*

that I last saw alive on

*Mar 16, 1928*and that death occurred, on the date stated above, at *11:50 P.M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

*Diabetes Mellitus*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

(Signed)

*1928* (Address)

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*Mrs. R. G. Elliott**3/20/28**1725**ashland*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE **E 31795**

REGISTERED NO.

**E 31795**CITY OF BALTIMORE: (No. **2441 Callow Ave.**ST. **13-54** WARD)2-FULL NAME **Clara Rice**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. **2441 Callow Ave.**

(Usual place of abode)

ST. WARD **Penn.**

Length of residence in city or town where death occurred

yrs. **2** mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) **Oct. 13th. 1879**

AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	48	5	5	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **Buyer: -Dept. Store.**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)**Pennsylvania.**10 NAME OF FATHER **Gustave Rice.**11 BIRTHPLACE OF FATHER (city or town)  
(State or country)**Germany.**12 MAIDEN NAME OF MOTHER **Pauline Rhonheimer**13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)**Germany.**Informant **Mr. A. Rice**  
(Address) **2441 Callow Ave.**

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **March 18th. 1928**

17

I HEREBY CERTIFY, That I attended deceased from **Jan 23<sup>rd</sup>**, 1928, to **March 18<sup>th</sup>**, 1928, that I last saw her alive on **March 17<sup>th</sup>**, 1928, and that death occurred, on the date stated above, at **6 A. m.**

The CAUSE OF DEATH\* was as follows:

**Abdominal Carcinoma -  
Primary in the Right Breast.**(duration) **2** yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? **yes** Date of **2 yrs ago**Was there an autopsy? **no**What test confirmed diagnosis? **Clinical**(Signed) **Eugene Douglas**, M. D.19 (Address) **3043 St. Paul St.**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL**Balto. Hebrew Cem.**

DATE OF BURIAL

**3/20/ 1928**

UNDERTAKER

ADDRESS

**118 2010 Mt.  
Royal Ave.**

E 31796

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31796  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Wolfe Street St. 2-4 Ward)2-FULL NAME JAMES E. KENLEY940 Fell Street

(a) RESIDENCE NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of \_\_\_\_\_ (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) May 5, 18727 AGE Years 55 Months 10 Days 11 IF LESS than 1 day.....hrs. \_\_\_\_\_ or.....min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Baltimore (State or country) \_\_\_\_\_10 NAME OF FATHER George Kenley11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) \_\_\_\_\_12 MAIDEN NAME OF MOTHER Margaret Foster13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country) \_\_\_\_\_14 Informant Mrs. Mollie Galloway (Sister) (Address) 211 S. Washington St.15 Filed 1928 Registrar \_\_\_\_\_

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Stenosis

## CONTRIBUTORY (Secondary)

Mar 17/28 (Signed) G. C. Hales (Coroner) M. D. (Address) 1436 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mount Carmel CemeteryMar. 18 1928

20 UNDERTAKER

Henry Sander & Sons IncADDRESS Baltimore St. & BROADWAY

E 31797

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE

(No. 2815 Violet Ave

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Jennie Kirsh

(a) RESIDENCE NO.

2815 Violet Ave

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

43 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

43 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

mar

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

Mose Kirsh

DATE OF BIRTH (month, day, and year)

unknown

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Ellya Lipsitz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Anton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

Informant

(Address)

Jack Lewis 1439 E. Baltimore

Filed

MAR 1 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/18 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1928, to March 18, 1928.

that I last saw her alive on March 18, 1928, and that death occurred, on the date stated above, at 11:10 P. M.

The CAUSE OF DEATH\* was as follows:

Anemia due to Chronic nephritis Myocarditis Hypertension (duration) 2 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

9 lungs (duration) 1 yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friedman, M. D.

19 (Address) 1013 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Hebrew Bur

DATE OF BURIAL

3/19 1928

UNDERTAKER

Jack Lewis 1439 E. Baltimore



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31798

## CERTIFICATE OF DEATH.

E 31798

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 HollinsST. 19-28 WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

2-FULL NAME Louise Harrison(a) RESIDENCE NO. 1622 Hollins

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred 75 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White 5 Single, Married, Widowed,  
or Divorced, (write the word) Widowa If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) March 2, 1853AGE Years 75 Months 16 Days 15 If LESS than  
1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work None(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country) md10 NAME OF FATHER John Roberts11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore md12 MAIDEN NAME OF MOTHER Ann Ramos13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Baltimore mdInformant Annie V. Van Arsdale  
(Address) 1622 Hollins StFiled 1928 19 \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 192817 I HEREBY CERTIFY, That I attended deceased from  
Feb. 1, 1928, to Mar 17, 1928,that I last saw him alive on Mar 17, 1928and that death occurred, on the date stated above, at 11 45 p. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Bladder.(duration) 2w3 yrs. mos. ds.CONTRIBUTORY myocardial infarction  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. B. Baum and Lord, M. D.3/18, 1928 (Address) 626 N. Gilman St\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

David Ridge  
20 UNDERTAKERMarch 19 1928George J. SmithADDRESS 1532  
Hollins

E 31799

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90-E 31799

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1458 W. Conico St. 21-28 WARD)

## 2-FULL NAME Josephine R. Baggett

(a) RESIDENCE NO. 1458 W. Conico St.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Saul J. Baggett

6 DATE OF BIRTH (month, day, and year) Aug 30, 1874

7 AGE Years 53. 6 Months 18 Days 11 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Some duties

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

W. W. Lightfoot

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cecilia

12 MAIDEN NAME OF MOTHER

Matilda Laffeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Joe R. Baggett 1458 W. Conico St.

15

Filed

MAR 21 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1928

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1928, to March 19, 1928.

that I last saw her alive on March 17, 1928.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Acute Cardiac dilatation (duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

W. B. Frilingger, M.D.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

Mar 21 1928

20 UNDERTAKER

George J. Smith Hollins

E 31800

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31800

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE

(No.

1621 N. Calvert

ST.

12-19

WARD)

## 2-FULL NAME

George C. Herschman

(a) RESIDENCE NO.

1621 N. Calvert

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed,

or Divorced, (write the word)

Married

a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Annie C. Herschman

DATE OF BIRTH (month, day, and year)

Mar 13, 1851

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

77

14

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.

Contractor

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Self.

BIRTHPLACE (city or town,  
State or country)

Baltimore Md

10 NAME OF FATHER

John Herschman

11 BIRTHPLACE OF FATHER (city or town,  
State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town,  
State or country)

Unknown

Informant  
(Address)Annie C. Herschman  
1621 N. Calvert St.

Filed

19

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 17, 1928

17

I HEREBY CERTIFY, That I attended deceased from

3/8, 1928, to 3/17, 1928.

that I last saw him alive on 3/17/28.

and that death occurred, on the date stated above, at 5:15 p. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia - r. l.

(duration)

yrs.

mos.

10 ds.

CONTRIBUTORY  
(Secondary)

Cardiac decompensation

(duration)

yrs.

mos.

1 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

George A. Barden, M. D.

3/18/28

(Address) 1817 E North Ave

State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Baltimore

DATE OF BURIAL

3/20, 1928

20 UNDERTAKER

Wm. Cook

ADDRESS

507 E North Ave

E 31801

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31801

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5708 Bellona Ave* *27-48* WARD)REGISTERED No. *129*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Joseph J. Gork*(a) RESIDENCE. No. *5708 Bellona Ave* ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *45* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Josephine Gork*

6 DATE OF BIRTH (month, day, and year)

*June 19-1884*

7 AGE

*73* Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*8 28*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Tailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Making & repairing of garments*

(c) Name of employer

*Self*9 BIRTHPLACE (city or town)  
(State or country)*Austria*

PARENTS

10 NAME OF FATHER

*Do not know*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Austria*

12 MAIDEN NAME OF MOTHER

*Do not know*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Austria*

14

Informant  
(Address)*John H. Gork  
5708 Bellona Ave*

15

Filed

19

*1928*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 17, 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*April 29, 1927*, to *March 17, 1928*,  
that I last saw him alive on *March 17, 1928*,  
and that death occurred, on the date stated above, at *4:51* m.

The CAUSE OF DEATH\* was as follows:

*Chronic nephritis &  
arteriosclerosis*(duration) *1* yrs. *to my knowledge* mos. ds.CONTRIBUTORY  
(Secondary)*Planning with effusion of pleurae  
& edema*  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *C. D. Seeman*, M. D.*3/18/1928* (Address) *3949 Greenmount Ave*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Club**3/20 1928*

20 UNDERTAKER

*W. B. Cook*

ADDRESS

*502 E. North*



E 31802

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

2

yrs.

7

mos.

ds.

How long in U. S. If of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)  
Widowed

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Edward Tear Taubman

DATE OF BIRTH (month, day, and year)

July 6, 1857

AGE

70

Years

Months

Days

If LESS than  
1 day.....hrs  
or.....min.

8

13

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Ohio

10 NAME OF FATHER

J. M. Kennedy

11 BIRTHPLACE OF FATHER (city or town)

Ireland

(State or country)

12 MAIDEN NAME OF MOTHER

Margaret Stuart

13 BIRTHPLACE OF MOTHER (city or town)

England

(State or country)

Informant  
(Address)

1121 Roland Avenue

Filed

1928

HARRISON JONES, R. L.

Registrar

E 31802

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)90  
27-53

ST.

WARD

WARD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 17 1928

17

I HEREBY CERTIFY, That I attended deceased from

3-15-28, 19 to 3-17-28, 19

that I last saw him alive on

3-18-28, 19

and that death occurred, on the date stated above, at

3:25 A.M.

The CAUSE OF DEATH\* was as follows:

~~Acute Infectious Endocarditis~~  
Myocarditis Chronic

(duration)

yrs.

mos.

3 wks.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

1121 Roland Ave.

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

F. Seraghty

M. D.

3/19/28 Address

W. M. H.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Aberdeen, South Dakota

DATE OF BURIAL

3/22 1928

20 UNDERTAKER

J. B. Cook

ADDRESS

1003 West  
Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31803

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

Length of residence in city or town where death occurred

yrs.

mos. 2 ds.

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

Malay

Unknown

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

About 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Fireman

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer Steamship City of Chester

9 BIRTHPLACE (city or town)

(State or country)

Berma

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

PARENTS

14

Informant Captain Letton

(Address) Steamship City of Chester

15

Filed

19

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March

18 1928

17

I HEREBY CERTIFY, that I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)Person and from the evidence obtained by said  
Inquest, au-  
topsy or inquiry.) and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH was as follows:

From R.R. Accident  
Traumatic Amp R Leg & Arm  
ShockCONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

3/19/19 28 Address 143 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Lorraine Cemetery

Date of Burial Mar. 19 19 28

20 UNDERTAKER

ADDRESS

1003 W.  
Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 South First ST. 70-1 WARD)2-FULL NAME Hugh Priddy Gannon(a) RESIDENCE NO. 8228 Broad

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

June 7 1926

AGE

Years

Months

Days

1912

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

City10 NAME OF FATHER Hugh Priddy Gannon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.12 MAIDEN NAME OF MOTHER Maril Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

City

Informant (Address)

H. P. Gannon  
8228 Broad

1928

F. HAMPSON JOHNS, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 192817 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1928, to March 19, 1928, that I last saw him alive on March 17, 1928, and that death occurred, on the date stated above, at 1:45 A m. The CAUSE OF DEATH\* was as follows:Tubercular Meningitis

(duration)

yrs.

mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 6 ds.

18 Where was disease contracted if not at place of death?

UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) H. A. Burdick

M. D.

1928 (Address) 2221 E. Baltimore St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Holy Rosary Cemetery March 20 1928

20 UNDERTAKER

ADDRESS

George W. Weber 2205 Bank St.

E 31805

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31805

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 9-17 WARD)2-FULL NAME Martha Jones(a) RESIDENCE NO. St. James Rectory ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Negro

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day..... hrs. or..... min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/28 19

17

I HEREBY CERTIFY, That I attended deceased from

3/13/28, 19, to 3/17/28, 19that I last saw her alive on 3/17/28, 19and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH\* was as follows:

lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Laurence Fahney, M. D.19 (Address) St. Joseph's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner of Health.

ADDRESS

JOHNS HOPKINS HOSPITAL

Registrar

1928

G. HAMPTON JONES, K. D.

P. W. W. WOODALL

MAR 19 1928





31807

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31807

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST., 1-2 WARD)2-FULL NAME Amanda Drews(a) RESIDENCE NO. 601 S Decker

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 0 mos.ST., 1-2 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) marrieda If married, widowed, or divorced HUSBAND of John Drews or WIFE ofDATE OF BIRTH (month, day, and year) Jan 26 - 1896AGE 32 years 1 Months 20 Days 21 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) md (State or country)10 NAME OF FATHER Wm Holland11 BIRTHPLACE OF FATHER (city or town) md (State or country)12 MAIDEN NAME OF MOTHER Anne13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

Informant (Address)

Filed 9-19-28

G. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17 19 28

17

I HEREBY CERTIFY, That I attended deceased from 3-15 19 28 to 3-17 19 28 that I last saw her alive on 3-17 19 28 and that death occurred, on the date stated above, at 11 15 P. m.

THE CAUSE OF DEATH\* was as follows:

Lobar PneumoniaCONTRIBUTORY (Secondary) Rheumatic Heart Disease with mitral stenosis + insufficiency (duration) yrs. mos. 2 ds.18 Where was disease contracted? ? if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Autopsy(Signed) C. J. Jones M. D. 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John Leeves2809

31808

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 31808

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2nd Gen Hosp 8-16 S. 6 Ward)2-FULL NAME Mrs Mary Benzel(a) RESIDENCE NO. 2230 E Hoffman St. 6 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) June 3, 18857 AGE 42 Years 9 Months 15 Days IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.  
(State or country)10 NAME OF FATHER Geo Schnapp11 BIRTHPLACE OF FATHER (City or town)  
(State or country) Germany12 MAIDEN NAME OF MOTHER Schane13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany14 Informant Hospital Records  
(Address)15 Filed 1528 G. H. Jones Registrar  
R. H.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18-28 19 2817 I HEREBY CERTIFY, That I attended deceased from 3/3, 19 28, to 3/18, 19 28, that I last saw her alive on 3/18, 19 28, and that death occurred, on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH\* was as follows:

Chr MyocarditisCONTRIBUTORY (duration) 1 yrs. 1 mos. 1 ds.  
(Secondary) Cardiac decomposition18 Where was disease contracted (duration) 1 yrs. 1 mos. 1 ds.  
If not at place of death? HomeDid an operation precede death? NO Date of NOWas there an autopsy? NOWhat test confirmed diagnosis? Clinical(Signed) C. C. Zimmerman, M. D.  
, 19 28 (Address) 2nd Gen Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Trinity ChurchMar 21 192820 UNDERTAKEN John Ullrich

ADDRESS

2008 Arlean

E 31809

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 921 S Kenwood Ave St., 17 Ward)2-FULL NAME Frank Cihon(a) RESIDENCE NO. 921 S Kenwood Ave St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. — mos. ds. (If non-resident give city or town and State)How long in U. S., if of foreign birth? 25 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) 18867 AGE 42 Years 41 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward(b) General nature of industry, business, or establishment in which employed (or employer) OH

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Poland10 NAME OF FATHER Michael Cihon

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland12 MAIDEN NAME OF MOTHER Antonina Meszanska

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

## 14

Informant Anna Cihon  
(Address) 921 S Kenwood Ave

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 19 28

17

I HEREBY CERTIFY, That I attended deceased from March 14, 19 28, to March 18, 19 28, that I last saw him alive on March 18, 19 28, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

myocardial infarction

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. .... mos. .... ds.

## 18 Where was disease contracted

If not at place of death at workDid an operation precede death? no Date of.....Was there an autopsy? noWhat test confirmed diagnosis? P. S. & S.(Signed) John V. Sybilinski, M. D., 19 (Address) 1738 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 3-21 19 28

## 20 UNDERTAKER

ADDRESS

Stephen Fialkowski 921 S Kenwood Ave

PARENTS





E 31811

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31811

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3140 Remington Ave.

ST. 12-51 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Agnes McClanahan

(a) RESIDENCE No. 3140 Remington Ave.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

James McClanahan

6 DATE OF BIRTH (month, day, and year) March 12th, 1884

7 AGE Years Months Days If LESS than 1 day, hrs or min. 44 0 7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Sheppardstown W. Va.

10 NAME OF FATHER George McCahan

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Unseld

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant

James McClanahan

(Address)

3140 Remington Ave.

15

9-1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1928

17

I HEREBY CERTIFY, That I attended deceased from August 1927, to Nov 18, 1928, that I last saw her alive on March 15, 1928 and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary

Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) F. J. Purley

M. D.

9/19, 1928 (Address) 110 E North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sheppardstown West Va.

3/21 1928

20 UNDERTAKER

ADDRESS

J. F. France 1180 N. Royal Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31812

E 31812

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3943 Canterbury Road Ward 2-49)2-FULL NAME Miss C. Kelly(a) RESIDENCE NO. 3943 Canterbury Road Ward 2-49

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Independence W. Kelly

## 6 DATE OF BIRTH (month, day, and year)

July 12, 1855

## 7 AGE

Years

Months

Days

IF LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min..73 1 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

retired

## 9 BIRTHPLACE (city or town)

(State or country)

a a Co  
Md

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant

(Address)

William Kelly George  
3943 Canterbury Road

## 15

File

1928  
G. HARRISON JONES  
MD  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 18 - 28

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar. 16, 1928, to Mar. 18, 1928.that I last saw her alive on March 17, 1928.and that death occurred, on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH\* was as follows:

Generalized Arterio-Sclerotic  
Coronary Arterial Hypertensionmany  
(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.CONTRIBUTORY Coronary thrombosis  
(Secondary)(duration) \_\_\_\_ yrs. \_\_\_\_ mos. 2 ds.

## 18 Where was disease contracted

If not at place of death? \_\_\_\_

Did an operation precede death? No Date of \_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Long(Signed) G. Carroll Lockard, M. D.\_\_\_\_\_, 1928 (Address) 4 E. Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park March 20 1928

## 20 UNDERTAKER

ADDRESS

John O. Mitchell 17 So. 19th St

E 31813

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

92 E 31813

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 706 E. 21st St

St. 9-46 Ward

2-FULL NAME Albert Henry Bush

(a) RESIDENCE NO. 706 E. 21st St

(Usual place of abode)

Length of residence in city or town where death occurred

St. Ward

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

white

5 Single, Married, Widowed, or Divorced, (write the word)  
widower5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Margaret (Hughes) Bush

6 DATE OF BIRTH (month, day, and year)

Apr 1/1845

7 AGE

Years

82

Months

11

Days

17

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Sailmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md.

10 NAME OF FATHER Geo. H. C. J. Bush

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER Ann E. Charles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant Alberta E. Bush

(Address)

706 E. 21st St

15

Filed

J. H. HARRISON, JR.,

Register

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 13/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Cardiac Embolism

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. HARRISON, JR. M. D.

3/19/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31814

## CERTIFICATE OF DEATH.

E 31814

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 218 E 20th St 12-50 Ward)

## 2-FULL NAME

Wm. E. Ammons

## (a) RESIDENCE NO.

218 E 20th St

St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Paul Ammons

## 6 DATE OF BIRTH (month, day, and year)

Mar 4 - 1876

## 7 AGE

Years

52

Months

Days

15IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

10

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Va.

## 10 NAME OF FATHER

Alexander Ammons

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Lucy Black

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va.

## 14

Informant  
(Address)Paul Ammons218 E. 20th StG. HARTSON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

## 17

I HEREBY CERTIFY, That I attended deceased from November 10, 1926 to Mar 19, 1928that I last saw him alive on March 19, 1928 and that death occurred, on the date stated above, at 11 A M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. .... mos. .... ds.

## CONTRIBUTORY

(Secondary)

(duration) 2 yrs. 4 mos. 9 ds.

## 18 Where was disease contracted

If not at place of death

Did an operation precede death? ..... Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

, 19

(Address)

2329 Guilford St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Richmond Va.3/21/1928

## 20 UNDERTAKER

ADDRESS

Mrs. L. H. Hollan, 1607 Duval St

9 1928

E 31815

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 31815**

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1)

2-FULL NAME Anna Olson

(a) RESIDENCE NO. 1446 Blevins.

(Usual place of node)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
-------	-----------------	--

5a If married, widowed, or divorced  
HUSBAND of  
or WIFE of

6 DATE OF BIRTH (month, day, and year) 3

7 AGE	Years	Months	Days	If LESS than 1 day, .... hrs. or .... min.
	11	0		

### A OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cover

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ...  
(State or country) \

10 NAME OF FATHER C. J. Jones C. J. Jones

11 BIRTHPLACE OF FATHER (city or town).....  
(State or country) 7

12 MAIDEN NAME OF MOTHER *Gene Collins*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14 Informant (Address) Reese, J. B.

15 FIND 19 HAMPTON JONES K. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/ 1928

17 I HEREBY CERTIFY, That I attended deceased from  
Mar. 12, 1928, to Mar. 14, 1928,  
that I last saw her alive on Mar. 14, 1928,  
and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic & acute  
arteriosclerosis:  
Hypertension.  
(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY .....  
(Secondary) .....  
..... (duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? *ho*

What test confirmed diagnosis? General & Sub

(Signed) C. Paulus Bond M.D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL	DATE OF BURIAL
	3/1/1

NO. 12 *W. A. ...* 19 *...*  
 UNDERTAKER ADDRESS

DATE OF BURIAL

3/19  
ADDRESS

E 31816

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31816

## 1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

City of BALTIMORE: (No. 3118 Shafford St., 7070 Ward)

Registered No. ....

2-FULL NAME Catherine Shalmanian

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 3118 Shafford

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 3 mos. 1 ds.

Now long in U. S., if of foreign birth? yrs. .... mos. .... ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS.

## MEDICAL CERTIFICATE OF DEATH.

3-SEX Female4-COLOR OR RACE White5-Single, married, widowed, or divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 17-1927

7-AGE

yrs. 3 mos. 1 ds.

If LESS than 1 day

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country) Balto10-NAME OF FATHER Sam Shalmanian11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto12-MAIDEN NAME OF MOTHER Eula E. Bonchoff13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto14- (Informant) S. Shalmanian  
(Address) 3118 Shafford16-DATE OF DEATH (month, day and year) 3-18-2817- I HEREBY CERTIFY, That I attended deceased from 3-17 to 3-18 1928That I last saw her alive on 3-17 1928 and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

be Branches pneumonia(Duration) yrs. .... mos. 2 da

CONTRIBUTORY (Secondary)

(Duration) yrs. .... mos. .... ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Phys and finding(Signed) M. A. Kuehl M. D.449, 1928 (Address) Shafford

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL, Mar 20, 192820-UNDERTAKER George L. Schmitt ADDRESS 201 Park Ave.

1928

G. HAMMON JONES, Registrar  
RECEIVED

E 31817

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31817

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 705 S. Sixth St. 76-37)2-FULL NAME Maria Loeffler(a) RESIDENCE NO. 705 S. Sixth St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. da. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Loeffler6 DATE OF BIRTH (month, day, and year) Mar. 6 - 18647 AGE 64 Years 63 Months 11 Days IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany  
(State or country)10 NAME OF FATHER Andrew Wachtel11 BIRTHPLACE OF FATHER (City or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Do not know13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Mary Wachtel  
(Address) 705 S. Sixth St.15 Filed 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19<sup>th</sup> 192817 I HEREBY CERTIFY, That I attended deceased from 3/12, 1928, to 3/17, 1928, that I last saw her alive on 3/16, 1928, and that death occurred, on the data stated above, at 5:52 a. m.

The CAUSE OF DEATH\* was as follows:

Arterio sclerosis  
MyocarditisCONTRIBUTORY (duration) yrs. mos. da. Cerebral Hemorrhage  
(Secondary)(duration) yrs. mos. da. 6 da.

18 Where was disease contracted

If not at place of death? noDid an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Gannell M. D.(Address) 633-5-34

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cemetery

Date of Burial

Mar. 20<sup>th</sup> 1928

20 UNDERTAKER

Lilly-Zeiler Inc.

ADDRESS

403 S. W. 11



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31818

## CERTIFICATE OF DEATH

E 31818

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3506 Clairmont Ave. 26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Krause

(a) RESIDENCE NO. 3506 Clairmont Ave. 26 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of Bernadina J. Krause  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day—hrs.  
or—min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar 1, 1927, to Mar 16, 1928.

that I last saw ~~him~~ alive on Mar 16, 1928.

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH\* was as follows:

Incurable  
(duration) yrs. 3 mos. ds.CONTRIBUTORY  
(Secondary)

Direct (duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mrs. B. Krause, M. D.

(Address) 319 19th St. N. W. Wash. D. C.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Oak Lawn Cemetery

Mar 20 1928

20 UNDERTAKER

ADDRESS

Lilly &amp; Ziehl Inc.

4000 Wood St.

E 31819

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31819

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Riverside Ave ST. 24-33 WARD)

2-FULL NAME Amelia Jones

(a) RESIDENCE No. 1435 Riverside Ave

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of Thomas Q. Jones (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8, 1845

7 AGE Years 82 Months 8 Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge, Md. (State or country)

10 NAME OF FATHER Wm. Reed

11 BIRTHPLACE OF FATHER (city or town) Delaware (State or country)

12 MAIDEN NAME OF MOTHER Amelia

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Miss Nellie B. Schlipper (Address) 1806 E. 3rd St.

15 G. HAMMOND JONES, R. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 19 28

17 I HEREBY CERTIFY, that I attended deceased from Feb 17 19 28, to March 18 19 28, that I last saw her alive on March 18 19 28,

and that death occurred, on the date stated above, at 3 P. m. The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. Schenck, M. D.

3/19/28 (Address) 1337 S. Charles Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

UNDERTAKER

Joseph B. Cook

DATE OF BURIAL

Mar. 21 19 28

ADDRESS

1003 West Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31820

## CERTIFICATE OF DEATH.

90 E 31820

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *German Aged Home* St. *20-27* Ward *1*)

## 2-FULL NAME

*Caroline Wellener*

## (a) RESIDENCE NO.

*German Aged Home* St. *20-27* Ward *1*

(Usual place of abode)

Length of residence in city or town where death occurred

*Life* mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 Color or Race

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced HUSBAND or (or) WIFE of

*Charles H. Wellener*

## 6 DATE OF BIRTH (month, day, and year)

*Oct. 23 1849*

## 7 AGE

Years

Months

Days

*78**4**21*IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

*Baltimore*

(State or country)

*Maryland*

## 10 NAME OF FATHER

*Henry H. Kottman*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Holland*

## 12 MAIDEN NAME (or MARRIAGE)

*Minnie King*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

## 14

Informant

(Address)

*Regent's German Aged Home  
Baltimore and Payson Sts.*

9 1928

*C. O. Johnson* Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 18 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*April 1927*, to *March 16<sup>th</sup> 1928*;that I last saw her alive on *March 16 1928*;and that death occurred, on the date stated above, at *1 A* m.

The CAUSE OF DEATH\* was as follows:

*Coronary Heart Disease*(duration) *1* yrs. *6* mos. *18* ds.CONTRIBUTORY *Branchial asthma*  
(Secondary)(duration) *1* yrs. *6* mos. *18* ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of *March 16 1928*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *John H. Overhoff*, M. D.

3/16/28 (Address) 1843 W. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*St. Carmel's**Mar. 20 1928*

## 20 UNDERTAKER

ADDRESS

*Joseph Cook**1003 N. Baltimore*

E 31821

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

100-801-  
E 31821  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 23 N Bradford 6-10 Ward)2-FULL NAME Henry Behrens(a) RESIDENCE NO. 23 N Bradford St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15 Filed

9 1928

C. HARRISON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
3-16-28 to 3-18-28  
that I last saw him alive on 3-17-28  
and that death occurred, on the date stated above, at 5 PM  
The CAUSE OF DEATH\* was as follows:CONTRIBUTORY  
(Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

State the Disease causing Death in death from violent causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS



E 31822

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31822

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1824 Fleet St. 2-4 Ward)

2-FULL NAME John Kasprzak

(a) RESIDENCE NO. 1824 Fleet St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 11 1877

7 AGE Years 51 Months 1 Days 4 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Killdrewer

(c) Name of employer

Bennett Pottery

## 9 BIRTHPLACE (city or town)

(State or country)

Poland

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

## PARENTS

14 Informant Josephine Kasprzak (Address) 1824 Fleet St.

15 Registrar C. HAMMOND JONES, R. W. 1928

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 15 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Rosary March 20 1928

## 20 UNDERTAKER

ADDRESS

John M. Weber 401 1/2 Chester St

31823

## HEALTH DEPARTMENT—CITY OF BALTIMORE 31823

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 S Robinson ST., 1-1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Schultz

(a) RESIDENCE NO. 1106 S Robinson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6 1881

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
46 8 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER Anthony Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anna Schultz (Address) 1106 S Robinson St.

15 File 1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 19 28

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1928, to March 16, 1928, that I last saw him alive on March 16, 1928, and that death occurred, on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH\* was as follows:

Intralaryngeal Carcinoma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY Myocardial Insufficiency (Secondary)

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 27, 21

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas, M. D.

Address 3037 O'Donnell St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Stanislaus March 20, 1928

20 UNDERTAKER

ADDRESS

John W. Weber 4012 Chester

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31824

## CERTIFICATE OF DEATH.

E 31824

## 1. PLACE OF DEATH

CITY OF BALTIMORE, (No. 1124 Cooke St. 24-35)

## 2. FULL NAME

Cornelius Coughlin

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE

1124 Cooke St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Dec. 25. 1873

## 7 AGE

Years

Months

Days

54

2

20

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Cornelius D. Coughlin

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Sarah Thomas

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14

Informant (Address)

John L. Coughlin  
2901 Belmont Ave

## 15

Filed

1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3. 18. 19 28

## 17

I HEREBY CERTIFY, That I attended deceased from

3. 14. 19 28 to 3. 18. 19 28

that I last saw him on

3. 18. 19 28

and that death occurred, on the date stated above, at

7 a m.

The CAUSE OF DEATH\* was as follows:

myocarditis  
chronic nephritis

## CONTRIBUTORY (Secondary)

(duration)

I don't know

(duration)

Pulmonary Edema

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical Examination

(Signed)

J. Edward Norris, M. D.

(Address)

107 East West St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

MOVING

Cathedral Cem

March 20, 28

## 20 UNDERTAKER

Margaret H. Flynn

## ADDRESS

1422 Light

E 31825

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31825

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 N. Wolfe

ST. 8-13 WARD)

## 2-FULL NAME

John H. Ries

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1107 N. Wolfe

ST. 8- WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Apr 9, 1884

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

43

6

9

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Meat cutter 013

## (b) General nature of industry, business, or establishment in which employed (or employer)

Meat market

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Gasper Ries

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Newark N.J.

## 12 MAIDEN NAME OF MOTHER

Mary Becker

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

## 14

## Informant (Address)

Louise McReinhardt 1107 N. Wolfe St.

## 15

9 1928

C. HAMMON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) Mar. 18, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar. 10 - 1928, to Mar. 18 - 1928.

that I last saw him alive on Mar. 17 - 1928.

and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary and periton- eal tuberculosis

(duration) One yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Gangrene of left fore arm

(duration) yrs. mos. ds.

## 18 Where was disease contracted (if not at place of death?) New Ark, N. J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

3/18/1928 (Address) 1223 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

Cedar Hill Cemo.

## DATE OF BURIAL

March 20, 1928

## 20 UNDERTAKER

Margaret L. Flynn

## ADDRESS

1422 Light



HEALTH DEPARTMENT <sup>Castro</sup> CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

E 31826

1-PLACE OF DEATH

City of BALTIMORE: (No. Sydenham Hospital)2-FULL NAME George H. Carter(a) RESIDENCE NO. 161 W. Henrietta St.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 Color or Race Black5 Single, Married, Widowed, or Divorced. (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Millie Carter  
~~WIFE of~~6 DATE OF BIRTH (month, day, and year) July 1869

7 AGE

Years

Months

Days

IF LESS than  
1 day... hrs.  
or... min..59

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14

Informant  
(Address)Millie Carter  
161 W. Henrietta St.Registrar R.H.K.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 192817 I HEREBY CERTIFY, That I attended deceased from March 15, 1928, to March 18, 1928, that I last saw him alive on March 18, 1928, and that death occurred, on the data stated above, at 11:55 a.m.The CAUSE OF DEATH\* was as follows:  
ErysipelasCONTRIBUTORY  
(Secondary)

18 Where was disease contracted

If not at place of death? At homeDid an operation precede death? No Date of NoWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) J. L. Reim, M. D.Mar 18 1928 (Address) Sydenham Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mr. Auburn20 UNDERTAKER John H. Toadon

Date of Burial

ADDRESS 1027

MAR 20 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31827

## CERTIFICATE OF DEATH

E 31827

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *7th St. Fairview* St. *15* Ward *16*)2-FULL NAME *Francis Warrington*(a) RESIDENCE NO. *7th St. Fairview*

(Usual place of abode)

St. *15* Ward *16*

Length of residence in city or town where death occurred yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male Colored Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Dec 10-1926*

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

*1 3 7*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

*Balto.*

(State or country)

10 NAME OF FATHER

*Francis Warrington*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*md*

12 MAIDEN NAME OF MOTHER

*Mary Proctor*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*md*

14

Informant (Address)

*Francis Warrington 7th St. Fairview*

15 Filed

*20 1928*

16

*1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Nov. 17/1928*17 I HEREBY CERTIFY, That I attended deceased from *Sept. 2, 1928* to *Nov. 17, 1928*that I last saw him alive on *Oct. 17/28*and that death occurred, on the date stated above, at *3:40 P.M.*

The CAUSE OF DEATH was as follows:

*Coronary*CONTRIBUTORY (duration) yrs. mos. da. *Branchial Pneumonia*

(Secondary)

(duration) yrs. mos. da. *5*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of *Nov. 17/28*Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *W. H. H. H.*

19

(Address) *1340 Charles*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Holy Cross*

Date of Burial

*Nov 21 1928*

20 UNDERTAKER

*John H. Toadum*ADDRESS *127**Harold Hill*

E 31828

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31828

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hop ST. 28-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jordan McKeen(a) RESIDENCE NO. 4404 Fernhill Ave. ST. West WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 2

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland10 NAME OF FATHER Jordan McKeen11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland12 MAIDEN NAME OF MOTHER Marie Frank13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14

Informant

(Address) 4404 Fernhill Ave.

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 17 1928 to Mar 19 1928that I last saw him alive on Mar 19 1928and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH\* was as follows:

Infant Drowning(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard J. Schmitt M. D.19. 1928 (Address) 15 "C" Ave. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Landon Park Mar 20 1928

20 UNDERTAKER

ADDRESS

W B Hipper 185 24 Balls

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31829

## CERTIFICATE OF DEATH.

99E 31829

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 Brompton ST. 14-20 WARD)2-FULL NAME John W. Johnson Jr.(a) RESIDENCE NO. 2029 Brompton

(Usual place of abode)

ST. \_\_\_\_\_

WARD \_\_\_\_\_

Length of residence in city or town where death occurred Life yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

How long in U. S., if of foreign birth? \_\_\_\_\_

yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX M4 COLOR OR RACE C5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) Oct 15-1921

AGE

Years 6Months 5Days 3

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER John W. Johnson Sr.11 BIRTHPLACE OF FATHER (city or town) Baltimore Md  
(State or country)12 MAIDEN NAME OF MOTHER Sarah Maddy13 BIRTHPLACE OF MOTHER (city or town) Va  
(State or country)Informant (Address) Sarah Johnson  
2029 Brompton St.Filed 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 26, 1928, to Mar 18, 1928 that I last saw him alive on March 18, 1928 and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH\* was as follows:

Bronchio Pneumonia

(duration) \_\_\_\_\_

mos. 14CONTRIBUTORY (Secondary) Intestinal Regurgitation

(duration) \_\_\_\_\_

yrs. \_\_\_\_\_

mos. 20ds. 218 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) Wm H Wright

M. D.

Address) 1209 Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Calver BurialDATE OF BURIAL 3/20 192820 UNDERTAKER Daniel E. CarterADDRESS 916Be ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31830

## CERTIFICATE OF DEATH.

90 E 31830

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 408 N. Fremont Ave., St. 18-26 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME Ethel Handy

(a) RESIDENCE NO. 408 N. Fremont Ave., St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female Negro Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Handy

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 41

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

10 NAME OF FATHER James Harris.

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Martha Honey

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant August Handy (Address) 408 N. Fremont Ave.,

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry find that said deceased came to her death topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) M. D. (Coroner)

3/19<sup>19</sup> 28 Address) 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

3-20 1928 ADDRESS 916

R 20 1926

F. J. JONES, M. D. Registrar

D. J. JONES

D. J. JONES

E 31831

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31831

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5234 Vincent* ST., *19-27* WARD)2-FULL NAME *Baris Doozay*(a) RESIDENCE No. *5234 Vincent*

(Usual place of abode)

ST., *19-27* WARDLength of residence in city or town where death occurred *10* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Cauc**Mar*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *1980*

AGE

Years

Months

Days

*48*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Lottery*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Howard Co Md*

10 NAME OF DECEASED

*Baris Doozay*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Not known*

12 MAIDEN NAME OF MOTHER

*Not known*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Not known*

Informant

(Address)

*Isabel Middleton*  
*5234 Vincent*

File

APR 20 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 17* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 25*, 19*28*, to *Feb 17*, 19*28*,that I last saw him alive on *Feb 16*, 19*28*,and that death occurred, on the date stated above, at *5:00* m.

The CAUSE OF DEATH\* was as follows:

*Organic Lesions of Heart*

CONTRIBUTORY

(Secondary)

(duration) yrs. *3* mos. ds.*Pulmonary Edema*(duration) yrs. *1* mos. ds.

18 Where was disease contracted

if not at place of death?

*No*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Maumun Bur**3-19-28*

UNDERTAKER

ADDRESS

*James Carter**Ca ml*

E 31832

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31832

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *627* *London* ST. *17-25* WARD)2-FULL NAME *Edwin Brown*(a) RESIDENCE NO. *629* *London* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. *6* mos. *23* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Cauc**Single*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Sept. 6, 27*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*6**13*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed *1028* 19 *28*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 19, 28*

17

I HEREBY CERTIFY, That I attended deceased from *3/19/28*, 19 *28*, to *3/19/28*, 19 *28*, that I last saw him alive on *3/18/28*, 19 *28*, and that death occurred, on the date stated above, at *8:15 A.M.*

The CAUSE OF DEATH\* was as follows:

*Bacterial pneumonia*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *14*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *A. C. Ellis*, M. D.(Address) *524 Mod con*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*My father's grave**3/20 1928*

UNDERTAKER

ADDRESS *916**Wm. E. Carter**See all*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31833

## CERTIFICATE OF DEATH.

E 31833

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

863 Park Ave

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Joseph L. Bligg

(a) RESIDENCE NO.

863 Park Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

7

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Aug 4, 1918

AGE

9

Years

Months

Days

7 13

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Philadelphia

10 NAME OF FATHER

James Bligg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Buelah Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

Informant (Address)

Buelah Bligg

863 Park Ave

Filed

1928

N. J. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 17, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 12, 1928, to Mar 17, 1928,

that I last saw him alive on Mar 17, 1928

and that death occurred, on the date stated above, at 7:50 m.

The CAUSE OF DEATH\* was as follows:

Congenital Syphilis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Syphilitic meningitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Wasserman

(Signed) Edgar Friedenreich, M. D.

, 19 (Address) 1616 Linden Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Park Cem

March 19, 1928

20 UNDERTAKER

ADDRESS

Chenoweth &amp; Son



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

31834

## CERTIFICATE OF DEATH.

129 E 31834

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 W 33rd St. 9-47

ST., WARD)

## 2-FULL NAME Fannie L. De Haven

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No. 606 W 33rd St.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Late William De Haven

7 DATE OF BIRTH (month, day, and year) Aug 3, 1848

8 AGE

79

Years

Months

Days

9 LESS than  
1 day, hrs  
or min.

## 10 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

11 BIRTHPLACE (city or town).  
(State or country)

12 NAME OF FATHER Unknown

13 BIRTHPLACE OF FATHER (city or town).  
(State or country) Unknown

14 MAIDEN NAME OF MOTHER Unknown

15 BIRTHPLACE OF MOTHER (city or town).  
(State or country) Unknown16 Informant  
(Address) 606 W 33rd St.

17 Filed

R 20 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1928

19

17

I HEREBY CERTIFY, That I attended deceased from  
March 14, 1928, to March 18, 1928,  
that I last saw her alive on March 17, 1928  
and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis and  
nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY  
(Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) J. N. Wilson, M. D.

, 19 (Address) 823 W 36th St

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL St. Marys Hospital

DATE OF BURIAL

March 2, 1928

UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31835

## CERTIFICATE OF DEATH.

E 31835  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *605 Hardyman* St., *16-76* Ward)2-FULL NAME *Harry Butler*(a) RESIDENCE NO. *605 Hardyman* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *37* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 Color or Race *br* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Unknown 1891*7 AGE Years *37* Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) \_\_\_\_\_10 NAME OF FATHER *Edw. P. Butler*11 BIRTHPLACE OF FATHER (city or town) *md*  
(State or country) \_\_\_\_\_12 MAIDEN NAME OF MOTHER *Jane Dorsey*13 BIRTHPLACE OF MOTHER (city or town) *md*  
(State or country) \_\_\_\_\_14 Informant *Edw. P. Butler*  
(Address) *1630 N. Vincent St*15 Filed *28 1928* 19 *MANFRED JONES, N. D.*  
Registrar *R. J. Jones*

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 17 1928*17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said *inquiry* Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Mental Stenosis*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
*of Houston*CONTRIBUTORY (Secondary) *Mar 18 1928*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) *Geo C. Lutz* D.  
(Coroner) *Blades*  
19 Address *1436 S. Bay*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
*Removal* *Ign* *Mar 20 1928*20 UNDERTAKER *Chase* ADDRESS *1400 Mosher*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31836

## CERTIFICATE OF DEATH.

REGISTERED NO. 31836

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8-12 ST., 90 WARD)

2-FULL NAME Robert Anderson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 208 Patterson Park Ave. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single  
If married, widowed, or divorced HUSBAND of (or) WIFE ofDATE OF BIRTH (month, day, and year) ?  
AGE Years Months Days If LESS than 1 day, hrs. or min. 72

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant (Address) Records

Filed 1928

C. H. JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17/1928

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1927, to Mar. 17, 1928 that I last saw him live on Mar. 17, 1928 and that death occurred, on the date stated above, at 5:40 P. m. The CAUSE OF DEATH\* was as follows:  
Pneumonia

(duration) yrs. mos. ds. 5

CONTRIBUTORY Myocarditis

(Secondary) duration) yrs. mos. ds. ?

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General &amp; Sub

(Signed) C. J. Jones, M. D.  
, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Cathedral

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Rita Wiedefeld 914 Green St. Bm

31837

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *54 W Biddle*)2-FULL NAME *Robert Lee Rawls*(a) RESIDENCE NO. *54 W Biddle*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 6, 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*5**4**13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School boy*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*W. L. Rawls*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*M. C.*

12 MAIDEN NAME OF MOTHER

*Anna Stump*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md*

14

Informant (Address)

*W. L. Rawls**54 W Biddle St*

15

Filed

20 1928

J. J. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 19, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar. 12, 1928*, to *Mar. 19, 1928*, that I last saw him alive on *March 14, 1928*, and that death occurred, on the date stated above, at *8:30 p. m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria**(Circu)*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*Pneumo-pneumonia*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Positive Culture*

(Signed)

, 19

(Address)

*2 E. Eager St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*St. Thomas Garrison For. Burial Soc.**1100 N. Holladay*



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 31838

## CERTIFICATE OF DEATH.

44E 31838

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Reisterstown Rd Hayward Ave*)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

66 yrs. 1 mos. 8

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Emily Eugenia Hardesty

## DATE OF BIRTH (month, day, and year)

Feb. 8 1862

## AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

66

1

8

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Richard W. Hardesty

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Rachel S. Wood

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

Informant (Address)

Mrs Emily E. Hardesty Reisterstown Rd Hayward Ave

Filed

1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 18 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Dec 1, 1927 to March 18, 1928

that I last saw him alive on March 17, 1928

and that death occurred, on the date stated above, at 6 4. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach (pyloric)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Yes

No

Date of

12/13/27

Was there an autopsy?

Yes

No

What test confirmed diagnosis?

Specimen - Log. mors. J. H. M.

(Signed)

Charles Fred Egan, M. D.

729 28 (Address)

Medical Arts Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Wood Ridge Cems

Mar. 20, 28

## 20 UNDERTAKER

Wm J. Parker &amp; Son

## ADDRESS

North Pa

E 31839

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 31839

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3903 Sursum Oak Ave.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Carl M. Greineisen

(a) RESIDENCE NO.

(Usual place of abode)

3903 Sursum Oak Ave.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

50

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Grace J. Greineisen

7 DATE OF BIRTH (month, day, and year)

June 24, 1846

8 AGE

Years

81

Months

8

Days

23

If LESS than

1 day, hrs or min.

## 9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Travelling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

S. Stein &amp; Co. N.Y.

10 BIRTHPLACE (city or town) (State or country)

Germany

11 NAME OF FATHER

Unknown

12 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

13 MAIDEN NAME OF MOTHER

Unknown

14 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

15

Informant (Address)

Mrs. Grace J. Greineisen 3903 Sursum Oak Ave.

16

Filed

MAR 20 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 18, 1928

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1924, to March 18, 1928, that I last saw him alive on March 18, 1928, and that death occurred, on the date stated above, at 8.10 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic Infectious Pyelitis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Warner M. D.

Mar 20 1928 (Address) 7604 Garrison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Mar 21, 1928

20 UNDERTAKER

Wm. J. Kuehn

ADDRESS

North St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31840

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3213 Brighton Ave. ST. 17 WARD)

## 2. FULL NAME Sarah Catherine Seidt

(a) RESIDENCE NO. 3213 Brighton Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 8 mos. 17 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony E. Seidt

6 DATE OF BIRTH (month, day, and year) July 1, 1866

7 AGE

Years 61

Months 8

Days 17

If LESS than 1 day, his or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

10 NAME OF FATHER Des. W. Barou

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.

12 MAIDEN NAME OF MOTHER Nancy Lowman

13 BIRTHPLACE OF MOTHER (city or town) Md.

14

Informant Mr. Anthony E. Seidt.

(Address) 3213 Brighton Ave.

AR 20 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1928

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1928, to March 18, 1928, that I last saw her alive on March 18, 1928, and that death occurred, on the date stated above, at 9.30 P. M.

The CAUSE OF DEATH was as follows:

Gastric Adenocarcinoma  
Myocarditis Mitral  
Stenosis Aortic  
duration 2 yrs. 8 mos. 1 ds.

CONTRIBUTORY (Secondary)

Cardiac Dilatation  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Jones

M. D.

19

(Address) 1744 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Cemetery

Mar 21, 28

20 UNDERTAKER

ADDRESS

Wm. Stickner Sons

North Ave.

E 31841

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

117 E 31841

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* *27-48* Ward)2-FULL NAME *George K. Horn Jr.*(a) RESIDENCE NO. *617 Ravenswood Ave. St.* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *33* yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 Color or Race

*White*

5 Single, Married, Widowed, or Divorced. (write the word)

*Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Edythe Ryder Horn*

6 DATE OF BIRTH (month, day, and year)

*Oct 17*

7 AGE

*32* Years

Months

*5*

Days

*2*

IF LESS than 1 day—hrs. or—min..

*1895*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Painter (PAINTER)*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Printing*

(c) Name of employer

*Father*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Geo K Horn*

11 BIRTHPLACE OF FATHER (City or town) (State or country)

*New Jersey*

12 MAIDEN NAME OF MOTHER

*Robert Adelle M. Laine*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*New Jersey*

14

Informant

(Address)

*Dr. H. H. Whitten*  
*4309 Gt. Rd.*

15

Filed

MAR 21 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/19/28* 1917 I HEREBY CERTIFY, That I attended deceased from *3/5/28* 19 to *3/19/28* 19 that I last saw him alive on *3/19/28* 19 and that death occurred, on the date stated above, at *5:30 a.m.* The CAUSE OF DEATH\* was as follows:*Gangrenous Appendicitis*CONTRIBUTORY (duration) yrs. mos. ds. *Intestinal Obstruction* 9 mos. 14 ds. (Secondary) *5 days duration* *Emphysema* 3 days duration

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *3/6/28*Was there an autopsy? *yes* Date of *3/19/28*What test confirmed diagnosis? *Operation*(Signed) *J. S. Winstead* M. D. 3-19-1918 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*LOUDON PARK CEM*

20 UNDERTAKER

*Robert Brokersson**Mar 21 1928*  
*Cathryn*  
*Hollens*  
*24*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31842

## CERTIFICATE OF DEATH

E 31842

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 Mosher St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 1712 Mosher St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word).

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

I HEREBY CERTIFY, That I attended deceased from

Mar 17 1928 to Mar 19 1928.

that I last saw her alive on Mar 19 1928.

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Labor Pneumonia (Bilateral)

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Schell, M. D.

, 19 (Address) 713 N. Henri

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

15 Filed

MAR 20 1928

Registrar

J. E. Schell, M. D.  
Chas. E. Hicks Jr. 1404 N. Charles

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31843

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore City Hosp 12-50* ST. *12-50* WARD)

### 2-FULL NAME

*Alice E. Mason*

(a) RESIDENCE NO. *215 East 24th*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred *81* yrs. *8* mos. *11* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Widow of the late Gen. A. Mason*

DATE OF BIRTH (month, day, and year) *July 2 - 1846*

AGE

Years

Months

Days

II LESS than 1 day, hrs. or min.

*81*

*8*

*16*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*William Thomas*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Maryland*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

*Berrie Scott 215 E - 21st*

File

19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 18 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 12*, 1928, to *March 18*, 1928,

that I last saw her alive on *March 18*, 1928,

and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

CONTRIBUTORY (Secondary) *Cerebral Arteriosclerosis* (duration) yrs. mos. ds. *7* yrs. mos. *2* ds. *Bronchopneumonia*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Symptoms & clinical findings* (Signed) *Philip Pearlstein* M. D.

3/19/28 (Address) *Baltimore City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*London Park*

DATE OF BURIAL

*3/21 1928*

20 UNDERTAKER

*Ben. Robert Son 2503 Edmondson*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31844

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

90 E 31844

REGISTERED NO.

CITY OF BALTIMORE: (No. *2517 Lauretta ave* ST. *10-69* WARD)2-FULL NAME *Carolina Corvinelli*(a) RESIDENCE NO. *2517 Lauretta ave* ST. *10-69* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *7* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? *7* yrs. *0* mos. *0* ds.

WARD

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female*4 COLOR OR RACE *white*5 Single, Married, Widowed, or Divorced, (write the word) *widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Antonio Corvinelli*6 DATE OF BIRTH (month, day, and year) *April 23 1860*

7 AGE

Years *67*Months *10*Days *26*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *H. W. 031*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Italy*10 NAME OF FATHER *Emmanuel Occhiorozzi*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *Teresina Benedetto*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

14

Informant *Broccoli Coropoli*  
(Address) *2517 Lauretta ave*

15

Filed *1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 18 1928*

17

I HEREBY CERTIFY, That I attended deceased from *3.15* 19*27*, to *3.18* 19*28*.that I last saw her alive on *3.18* 19*28*.and that death occurred, on the date stated above, at *9 p.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic valvular heart disease*(duration) *1* yrs. *6* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Chas. Lesta* M. D.19 (Address) *726 W. Fayette st.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Geo. J. Ruth**3/23 1928*

20 UNDERTAKER

ADDRESS

*Holy Redeemer Cemetery 1735 Harford ave*

E 31845 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31845

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 N Montford St. 6-10)

## 2-FULL NAME

Mose. E. Carter

(a) RESIDENCE. No. 221 N Montford St.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

1861

7 AGE

67 yrs

Months

3

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Vir

10 NAME OF FATHER

Munkin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Munkin

12 MAIDEN NAME OF MOTHER

Munkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Munkin

14

Informant (Address)

Mabel. Johnson

15

Filed

221 N Montford St. Baltimore

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 18 1928

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1928, to March 18, 1928,

that I last saw him alive on March 17, 1928,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Intestinal Nodulitis  
Chronic Arterial Hypertension

(duration)

2 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Myocardial Infarction  
Pulmonary Embolism

(duration)

2 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. E. Geyer

M. D.

19 (Address)

156 N. Melton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Asbury Cemetery March 21 1928

20 UNDERTAKER

Milton. Davis 413 N. York St.

DATE OF BURIAL

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31846

E 31846

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single Married, Widowed,  
or Divorced, (write the word)5a If married, widowed or divorced  
HUSBAND of  
or WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

1928

March

1928

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 12, 1928, to March 18, 1928

that I last saw her alive on

March 17, 1928

and that death occurred, on the date stated above, at

D

m.

The CAUSE OF DEATH\* was as follows:

Cerebral apoplexy

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

ns

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

J. J. G. M. D.

19 (Address)

117 M. N. W. St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Baltimore Cemetery

3/21/1928

J. A. Moran

E. B. Moran

E 31847 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31847

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital 19-28* WARD)2-FULL NAME *Mary Ellen Basil*(a) RESIDENCE NO. *715 S. Gilman* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *WHITE* 5 Single *Married* Widowed, Divorced, (write the word) *Widow*If married, widowed, or divorced HUSBAND of (or) WIFE of *Louis V. Basil*DATE OF BIRTH (month, day, and year) *Jan 2-1859*AGE *69* Years *2* Months *17* Days If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Maryland* (State or country)10 NAME OF FATHER *Isaac Smith*11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)12 MAREN NAME OF MOTHER *Luene Taylor*13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)Informant *Louis V. Basil* (Address) *507 S. Fulton Ave*Filed *1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-19-28*17 I HEREBY CERTIFY, That I attended deceased from *2-16*, 19 *28*, to *3-19-28* that I last saw her alive on *3-19*, 19 *28* and that death occurred, on the date stated above, at *5-40* m.The CAUSE OF DEATH\* was as follows: *Chronic Myocarditis - Generalized Atherosclerosis*CONTRIBUTORY (Secondary) *Unknown* (duration) *Unknown* yrs. mos. ds. *Brachy pneumonia* (duration) *3* yrs. mos. ds.18 Where was disease contracted if not at place of death? *Same*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physiognomy* (Signed) *W. S. Taylor*, M. D. (Address) *Balti City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *London Park* DATE OF BURIAL *Jan 22nd 28*20 UNDERTAKER *W. S. Taylor* ADDRESS *1723 N. Bay*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31849

## CERTIFICATE OF DEATH.

129 ✓  
E 31849  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1036 Leadenhall St. St. 23-31 Ward)

## 2-FULL NAME

John Jesse C. Coleman. (C)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 1036 Leadenhall St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3:SEX Male. 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Annie Coleman. (C)

6 DATE OF BIRTH (month, day, and year) August 3, 1889.

7 AGE Years 33 Months 7 Days 14 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Florida.

10 NAME OF FATHER Allen Coleman. (C)

11 BIRTHPLACE OF FATHER (city or town) Florida.  
(State or country)

12 MAIDEN NAME OF MOTHER Jane (C)

13 BIRTHPLACE OF MOTHER (city or town) Florida.  
(State or country)14 Informant Annie Coleman. (C) wife.  
(Address) 1036 Leadenhall St.

15 Filled 19 20 1925 Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1928 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

8/20, 1923 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

## 20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31850

## CERTIFICATE OF DEATH.

E 31850

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 218 S. Greene St. St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cynthia Green(a) RESIDENCE NO. 218 S. Greene

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

Negro

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Frank Green

6 DATE OF BIRTH (month, day, and year)

1864.

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

64

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country)

S. C.

10 NAME OF FATHER

S. Harris

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Unknown

14

Informant

William Powell

(Address)

218 S. Greene St.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 18

1928.

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry find that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(Signed)

(Coroner)

3/19 28. Address 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs.,.....mos.,.....ds.

In the

State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

15 Filed

MAR 23 1928

Registrar

21



# HEALTH DEPARTMENT—CITY OF BALTIMORE

31852

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

40

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Fe

w

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Geo E. W. Wint

6 DATE OF BIRTH (month, day, and year)

1/7/1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

67

2

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Carmall Co.

10 NAME OF FATHER

John Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md.

12 MAIDEN NAME OF MOTHER

Annie Stigebauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Rock Hall md.

Informant (Address)

Geo W. Wint

Filed

MAR 20 1928

HARRISON JONES, R. E. L.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 10, 1928, to Mar 15, 1928, that I last saw her alive on Mar 15, 1928, and that death occurred, on the date stated above, at 11:20 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach

(duration) 3 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

Cardiac decompensation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

if not at place of death? same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl. &amp; Phy. Exam.

(Signed) Fred 7. Kyper, M. D.

19 (Address) 3321 Frederick Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

MOYAL

DATE OF BURIAL

Healy Chapel Rock Hall

Mar 21, 1928

20 UNDERTAKER

ADDRESS

J. S. Marshall 3589 Falls Rd

E 31853 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 31853  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 748 Dolphin St. 17-24 WARD)

## 2-FULL NAME Annie Combs

(a) RESIDENCE No. 748 Dolphin St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Lif yrs. mos. ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

M

col

married

5a If married, widowed, or divorced  
HUSBAND or WIFE of

Walter Combs

6 DATE OF BIRTH (month, day, and year)

Mar. 28/1893

7 AGE

34 Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

32

11

18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Maid 70

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

10 NAME OF FATHER

Jno. Combs

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Bertha Jones

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

14

Informant  
(Address)Bertha Jones  
748 Dolphin St.  
Baltimore, Md.

15

Filed

1928

G. E. JOHNSON JONES, R.  
1776 Edmonson

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 18/28

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 7, 1928, to Mar 16, 1928.

that I last saw him alive on

Mar 16, 1928

and that death occurred, on the date stated above, at

1101 m.

The CAUSE OF DEATH\* was as follows:

Colic and Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

C. E. Jones, M. D.  
1776 Edmonson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

St. Claburne

3/20/28

FUNERAL

ADDRESS

Samuel Hensley



*Grande*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31854

## CERTIFICATE OF DEATH.

E 31854

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST., \_\_\_\_\_ WARD)

2-FULL NAME *Etelle Grande*(a) RESIDENCE No. *324 S. Calverton* ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Married*

5a If married, widowed, or divorced

HUSBAND of

or) WIFE of

*Louis Grande*6 DATE OF BIRTH (month, day, and year) *?*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*30**34*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Maryland*10 NAME OF FATHER *?*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *?*12 MAIDEN NAME OF MOTHER *?*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *?*

14

Informant

(Address)

*Records*

15

Filed

20 1928

NANCY JONES, R. E.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/17/1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 14, 1928, to Mar. 17, 1928.*that I last saw him alive on *Mar. 17, 1928.*and that death occurred, on the date stated above, at *11:00 P. m.*

The CAUSE OF DEATH\* was as follows:

*Sole pneumonia*(duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary)

*Chronic* (duration) *14* yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *C. J. Holmes* M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Louder Park*

DATE OF BURIAL

*Mar 21 1928*

20 UNDERTAKER

*Thos. J. Fields 1200 W. Lombard*

ADDRESS

E 31855

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31855

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals W.B. 25 WARD)2-FULL NAME Julia Robinson(a) RESIDENCE No. 243 N. Pearl st.(Usual place of abode) UnknownLength of residence in city or town where death occurred Unknown yrs. mos.ST. Unknown WARD Unknown  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO. 101-901  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Percy Robinson  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18977 AGE 31 Years 30 Months 0 Days 0  
If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) North Carolina  
(State or country)10 NAME OF FATHER Willian Sheron11 BIRTHPLACE OF FATHER (city or town) North Carolina  
(State or country)12 MAIDEN NAME OF MOTHER Lucy Mayo13 BIRTHPLACE OF MOTHER (city or town) North Carolina  
(State or country)14 Informant Hospital Records  
(Address)15 Filed W. H. HANCOCK JONES, R. L.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 192817 I HEREBY CERTIFY, That I attended deceased from March 8, 1928, to March 16, 1928,  
that I last saw her alive on March 16, 1928,  
and that death occurred, on the date stated above, at 6:45 a.m.  
The CAUSE OF DEATH\* was as follows:Lobar Pneumonia11 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted Unknown  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Clinical & Autopsy  
(Signed) E. M. Madden M. D.3-16-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Calvary Cemetery DATE OF BURIAL March 17, 192820 UNDERTAKER Ernest Price ADDRESS 119 W. Henrietta

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31856

## CERTIFICATE OF DEATH

E 31856  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 122 N Luzerne Ave 6-10 Ward)2-FULL NAME Wilhelm Franke(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)(a) RESIDENCE NO. 122 N Luzerne Ave 6-10 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. 5 ds. How long in U. S. if of foreign birth? 6 yrs. 5 mos. 5 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of Caroline Franke  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Oct 29<sup>th</sup> 18457 AGE 83 Years 4 Months 20 Days IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Germany10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany14 Informant Dr. Chas Franke  
(Address) 122 N Luzerne Ave15 Filed 1928, 19

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 192817 I HEREBY CERTIFY, That I attended deceased from March 19 1928 to March 19 1928, that I last saw him alive on March 19 1928, and that death occurred, on the date stated above, at 5:51 P.

The CAUSE OF DEATH\* was as follows:

Cerebral Anoplexy  
Hemiplegia (Left side)(duration) 1 yrs. 1 mos. 1 da.CONTRIBUTORY  
(Secondary)Myocardial Infarction  
Pulmonary Edema(duration) 1 yrs. 1 mos. 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of March 19 1928Was there an autopsy? YesWhat test confirmed diagnosis? W. G. Geyer(Signed) W. G. Geyer M. D.19 (Address) 156 N. Milton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St Matthews3/22 1928

20 UNDERTAKER

ADDRESS

Louis Heumann32 S B Way

E 31857

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2601 E. Madison* ST. *13-59* WARD)

## 2-FULL NAME

*Infant of Wm & Margaret Steinbaugh*

## (a) RESIDENCE NO.

*2601 E. Madison*

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*M*

## 4 COLOR OR RACE

*W*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *3-18-28*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Balt ind.*

## 10 NAME OF FATHER

*Wm Steinbaugh*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balt ind*

## 12 MAIDEN NAME OF MOTHER

*Margaret Berholt*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balt ind*

## 14

Informant (Address)

*Wm Steinbaugh 2601 E. Madison*

## 15

*C. HAMPTON JONES, R. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-20-1928*

17

I HEREBY CERTIFY, That I attended deceased from *3/18*, 19 *28*, to *3/19*, 19 *28*.that I last saw him alive on *3/19*, 19 *28*.and that death occurred, on the date stated above, at *5:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Pneumonia*

(duration) yrs. mos. /ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Physical*(Signed) *A. H. Hornstein* M. D.1900, 19 *28* (Address) *753 Asquith St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*London Park*

## 20 UNDERTAKER

*John Ullrich*

## DATE OF BURIAL

*March 22 1928*

## ADDRESS

*2008 Ocean*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31858

E 31858

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Sinai Hospital

CITY OF BALTIMORE: (No.

3824 Fernwood Ave

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles L. Gainer

(a) RESIDENCE NO.

3824 Fernwood Ave

(Usual place of abode)

Length of residence in city or town where death occurred

40

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced. (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Anna Nally

6 DATE OF BIRTH (month, day, and year)

2/8/1888

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

40

1

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workStreet Cleaning  
Foreman(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Balto City

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

10 NAME OF FATHER

Henry Gainer

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balto

12 MAIDEN NAME OF MOTHER

Eva Kloppenberg

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Balto

14

Informant  
(Address)Mrs Anna Gainer  
3824 Fernwood Ave

15

Filed

19 HAMMON JONES, K. E. B.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 19 1928

17

HEREBY CERTIFY, That I attended deceased from  
3/16, 1928, to 3/19, 1928.

that I last saw him alive on

3/19/1928

and that death occurred, on the date stated above, at

7 P.

The CAUSE OF DEATH\* was as follows:

Respiratory Failure

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

Bronchial Asthma

(duration) 10 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Signs

(Signed)

Wm. J. Gainer, M. D.

, 19

(Address)

Sinai Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Oak Lawn Cem.

DATE OF BURIAL

3/23/28

20 UNDERTAKER

John Allen 2008 Orleans

E 31859

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31859

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospital (T. 315 ST. 315 WARD))REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2. FULL NAME Jack Laritzki(a) RESIDENCE No. 108 Albemarle st.(Usual place of abode) Unknown ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(If non-resident give city or town and State)  
Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of Unknown7 DATE OF BIRTH (month, day, and year) 18768 AGE Years 51 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or min. \_\_\_\_\_

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) Poland10 NAME OF FATHER Geo. Larizski,11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Poland12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) Poland14 Informant Hospital Records  
(Address) \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 192817 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1927, to March 16, 1928, that I last saw him alive on March 16, 1928, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted \_\_\_\_\_  
if not at place of death? UnknownDid an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Urinalysis & Lab(Signed) J. E. M. M. D. M. D.  
3-16-28 Baltimore City Hospitals  
(Address) \_\_\_\_\_

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL MAR 20 1928

UNDERTAKER

ADDRESS

Filed

19

C. HAMMON JONES, R. D. Registrar

Registrar

JOHNS HOPKINS HOSPITAL  
Commissioner Health.



E 31861

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31861

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *60 S Cammellton* *18-29* Ward)

Registered No. ....

2-FULL NAME *Baby Ruby*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *60 S Cammellton* *Ans.* Ward. ....

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *White*5-Single, Married, Widowed, or Divorced (Write the word) *Single*

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) *Mar 11-28*7-AGE, *9* yrs. .... mos. .... ds. .... hrs. or .... min.?

If LESS than 1 day,

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), *Baltimore Md*

PARENTS

10-NAME OF FATHER, *Raymond Ruby*11-BIRTHPLACE OF FATHER (city or town) (State or Country), *Md.*12-MATERN NAME OF MOTHER, *Theresa Herman*13-BIRTHPLACE OF MOTHER (city or town) (State or Country), *Md.*

14-

(Informant) *Raymond Ruby*(Address) *60 S. Cammellton*

15-

0-1928

C. HAMMOND JONES, M. D. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). *3-20-28*17- I HEREBY CERTIFY, That I attended deceased from *3-11-28* to *3-20-28*that I last saw him alive on *3-19-28*and that death occurred, on the date stated above, at *4404* m.

The CAUSE OF DEATH\* was as follows:

*See complete close of forum*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Dr. H. C. Schum*(Address) *2757 W. Monroe*

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVA *Western Cemetery*DATE OF BURIAL *Mar 21, 1928*20-UNDERTAKER, *Joseph 87 per*ADDRESS *608 W. North*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31862

## CERTIFICATE OF DEATH.

90 E 31862

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3100 Baker* ST. *16-67* WARD)2. FULL NAME *Mary Jane Rogers*(a) RESIDENCE NO. *3106 Baker* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *65* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

*Michael Warner Rogers*6 DATE OF BIRTH (month, day, and year) *Mch. 18-1857*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*71**1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*New York State*10 NAME OF FATHER *Michael Henry*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*England*12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*

14

Informant

(Address)

*William Rogers*  
*3100 Baker St.*

15

O 1928

G. HAMMOND JONES, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/19* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from

*3/16*, 19*28*, to *3/19*, 19*28*.that I last saw her alive on *3/19*, 19*28*.and that death occurred, on the date stated above, at *4:30* p. m.

The CAUSE OF DEATH\* was as follows:

*chronic myocarditis with moderate arteriosclerosis*(duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*acute Coronary Tuberculosis**subacute*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*Same*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Phys. Examination*

(Signed)

*J. S. O'Neil*

M. D.

*3/20/28* (Address) *804 Cathedral St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

*Greenmount Cem. Mch 21 1928*

20 UNDERTAKER

ADDRESS

*Chas. E. Franck 802 Madison*

E 31863

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31863

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2800 Evergreen Ave., Hamilton ST. 27-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOHN FREDERICK SEGELKEN

(a) RESIDENCE No. 2800 Evergreen Ave., Hamilton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Segelken

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1833

7 AGE Years 94 Months 6 Days — If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Sea Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 25 years

(c) Name of employer

9 BIRTHPLACE (city or town) Bremen Hafen (State or country) Germany

10 NAME OF FATHER Fred Segelken

11 BIRTHPLACE OF FATHER (city or town) (State or country) German

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mrs. Frederick Heimbuch (Address) 2800 Evergreen Ave., Hamilton

15 1928 C. HAMPTON JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1928

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1928, to March 19, 1928, that I last saw him alive on March 18, 1928, and that death occurred, on the date stated above, at 4:15 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary edema

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ds. Arteriosclerosis yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Jones, M. D. 19 (Address) 4706 Hampton Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Ann's Cemetery

March 28

20 UNDERTAKER

ADDRESS

Frederick Heimbuch Sons

Fullerton

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31864

## CERTIFICATE OF DEATH

90 E 31864

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 217 E University Parkway 12-49 Ward)

2-FULL NAME Elisabeth Hoengen

(a) RESIDENCE NO. 217 E University Parkway St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred Life yrs. mos. ds. (Usual place of abode) (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Late Martin Hoengen6 DATE OF BIRTH (month, day, and year)  
April 8, 1849

7 AGE	Years	Months	Days	IF LESS than 1 day—hrs. or—min..
78		II	IO	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Md.

10 NAME OF FATHER Frederick Conrod

11 BIRTHPLACE OF FATHER (City or town)  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Dietrich

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany14 Informant Clara L. Rheinhardt  
(Address) 217 E University Parkway

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 18, 1928.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1928, to March 18, 1928.

that I last saw him alive on March 18, 1928, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Mitral Insufficiency

CONTRIBUTORY  
(Secondary)

(duration) Unknown yrs. mos. ds.

(duration) yrs. 1 1/2 mos. ds.

18 Where was disease contracted

If not at place of death? ☒Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry B. Hays, M. D.

(Address)

32928 2504 20th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

Date of Burial

3/21 1928

20 UNDERTAKER

ADDRESS

Harry N. Vitzke 1531 W. Lombard

20 1928

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31865

31865

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5112 Norwood Rd. ST., 27-49 WARD)2-FULL NAME Mrs. Marie Gertrude Holdridge(a) RESIDENCE No. 5112 Norwood Rd. ST., 27-49 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 52 mos. 52 ds. How long in U. S., if of foreign birth? 52 yrs. 52 mos. 52 ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Widowed5a If married, widowed, or divorced HUSBAND of Hubert Holdridge (or) WIFE of6 DATE OF BIRTH (month, day, and year) Dec. 27, 497 AGE Years 78 Months 7 Days 23 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland (State or country)10 NAME OF FATHER Reemond Armstrong11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Genevieve Holdridge (Address) 5112 Norwood Rd.15 C. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 192817 I HEREBY CERTIFY, That I attended deceased from March 19, 1928, to March 20, 1928, that I last saw her alive on March 20, 1928, and that death occurred, on the date stated above, at 12 50 P. m.The CAUSE OF DEATH\* was as follows: Cerebral Thrombosis

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Carl H. Benson M. D., 19 (Address) 5111 York Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Catskill N. Y. DATE OF BURIAL Mar 20 192820 UNDERTAKER Harry N. Witzke ADDRESS 1531 W. Lombard St.



E 31866

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31866

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 134 S. East Ave St. 1-2 Ward)2-FULL NAME James Thomas Lambert Jr.(a) RESIDENCE NO. Colgate Md St.  Ward 

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of 6 DATE OF BIRTH (month, day, and year) Jan 5 19217 AGE Years 7 Months 2 Days 15 IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) Colgate (State or country) Baltimore Md10 NAME OF FATHER James T Lambert11 BIRTHPLACE OF FATHER (City or town) Colgate Md

(State or country)

12 MAIDEN NAME OF MOTHER Irene B. Burbett13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md

(State or country)

14 Informant Mr. James T Lambert (Address) Colgate Md

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 192817 I HEREBY CERTIFY, That I attended deceased from March 5 1928, to March 20 1928, that I last saw him alive on March 20 1928, and that death occurred, on the date stated above, at 11:50 am

The CAUSE OF DEATH\* was as follows:

Septicemia following cellulitis left orbit - occluding lacrimal canal(duration) yrs. mos. 14 ds.CONTRIBUTORY meningitis - hypopneumonia (Secondary)(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death? Colgate, Baltimore MdDid an operation precede death? Yes Date at March 8 '27Was there an autopsy? no opening of lacrimal canal

What test confirmed diagnosis?

(Signed) A. W. Wright M. D. 3/20/1928 (Address) 1014 S. Ellwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak LawnDate of Burial March 23 192820 UNDERTAKER John DerryADDRESS 715 E. 15th St

1928 G. HARRISON JONES, M. D. Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31867

## CERTIFICATE OF DEATH

179 E 31867

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 315 Collins Ave. St. 10 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alberta Fischer(a) RESIDENCE NO. 315 Collins Ave. St. 10 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 1 mos. 23 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female white Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 26 1876

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

52 1 23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md

10 NAME OF FATHER

Herman E. Fischer

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Virginia Carter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

14

Informant (Address)

Mrs George Kauffman  
315 Collins Ave

0 1928

HAROLD JONES, R. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 24 1926 to March 20 1928that I last saw her alive on March 2 1928and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis  
Internal Hemorrhage(duration) 24 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. Lloyd Johnson M. D.(Address) Friedrich & Augustus

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Baltimore Cemetery 23 10 28

20 UNDERTAKER

ADDRESS

for Joesdant Don 2178 Don

E 31868

*Helen E. Chaney*  
 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31868

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *831 Union Ave.*)ST. *13-52* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Helen E. Chaney,*(a) RESIDENCE No. *831 Union*

(Usual place of abode)

ST., *13-52* WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. *—* mos. *—* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Single~~, Married, Widowed, or Divorced; (write the word)*Female**White**Married*

5a If married, widowed, or divorced

*Widowed*  
(or) WIFE of*Roland J. Chaney,*6 DATE OF BIRTH (month, day, and year) *June 7, 1899*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*28**9**13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md.*10 NAME OF FATHER *William A. Nicholson,*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Baltimore Md.*12 MAIDEN NAME OF MOTHER *Eugenie E. Wier,*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Baltimore Md.*

14

Informant  
(Address)*Miss M. E. Nicholson  
3713 Edmondson Ave.*15 *1928**C. HAMMON JONES, R. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

*March 9, 1928* to *March 20, 1928*that I last saw her alive on *March 19, 1928*and that death occurred, on the date stated above, at *12:30* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*(duration) yrs. *7* mos. *—* ds.CONTRIBUTORY  
(Secondary)(duration) yrs. *7* mos. *—* ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Ben M. Wier*, M. D.(Address) *400 N. Payson*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*London Park*  
*Geo W Little*

E 31869

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31869

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 M. Livingston, ST. 20-27 WARD)

## 2. FULL NAME

Bertha C. Winter

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1927 M. Livingston

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widow

6a If married, widowed, or divorced HUSBAND or (or) WIFE of

Louis Winter

6 DATE OF BIRTH (month, day, and year) Apr 28/45

7 AGE Years 82 Months 10 Days 21 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bates Md.

## 10 NAME OF FATHER

Rocoker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Catherine Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## PARENTS

14 Informant Miss Catherine Winter (Address) 1927 M. Livingston St.

15 1928 G. HAMMOND JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1928

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1928, to Mar 20, 1928, that I last saw her alive on Mar 19, 1928, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH\* was as follows:

Hypertension + arterial sclerosis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 6

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? manual tests

(Signed) H. C. Kniff, M. D.

(Address) 4125 Edmondson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31870

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2104 Mura2-FULL NAME John Freitag(a) RESIDENCE NO. 2104 Mura St

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

St. 8-12 Ward)

St. \_\_\_\_\_ Ward \_\_\_\_\_

E 31870  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma Freitag

6 DATE OF BIRTH (month, day, and year)

April 24/1882

7 AGE 45 Years

44

Months

10

Day

25

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Buckstors

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto.

(State or country)

10 NAME OF FATHER

John Freitag

11 BIRTHPLACE OF FATHER (city or town)

Balto

(State or country)

12 MAIDEN NAME OF MOTHER

Louisa Weisel

13 BIRTHPLACE OF MOTHER (city or town)

Balto.

(State or country)

14

Informant (Address)

Marg. Moran 2104 Mura St.

15

Filed

19

JAMES JONES, J. J.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

Mar 19

17

I HEREBY CERTIFY, That I attended deceased from Mar 17, 1928, to Mar 19, 1928, that I last saw him alive on Mar 19, 1928, and that death occurred, on the date stated above, at 10<sup>00</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Pulver Pneumonia

(duration) .....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Mar 20, 1928 (Address)

Physical Signs  
M. D.  
1301 N. Pat St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer

March 22, 1928

20 UNDERTAKER

ADDRESS

Jos. J. Herrera Son 156 N. Luzerne

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31871

## CERTIFICATE OF DEATH.

90 E 31871

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *201 East Lafayette St.* WARD *14-19*)2. FULL NAME *Thomas Turner*(a) RESIDENCE NO. *201 East Lafayette St.* WARD *14-19*

(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. mos. ds.

Now long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Real Estate*(b) General nature of industry, business, or establishment in which employed (or employer) *Business*(c) Name of employer *Self*9 BIRTHPLACE (city or town) (State or country) *England*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *England*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *England*

14

Informant (Address) *Nathan Silverstone 111 St Charles St*

15

Filed *21 1928*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-20-1928*

17

I HEREBY CERTIFY, That I attended deceased from *Sept 18, 1927*, to *March 20, 1928*, that I last saw him alive on *March 18, 1928*, and that death occurred, on the date stated above, at *6 P. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular Heart Disease*CONTRIBUTORY (Secondary) *as above to*18 Where was disease contracted if not at place of death? *Don't know*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Heart*(Signed) *J. J. Jones*, M. D.320 1928 (Address) *177 W. Saratoga St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Nordlaun*DATE OF BURIAL *3/21/28*20 UNDERTAKER *William Cook*ADDRESS *502 E. N. St*

E 31872

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

90 E 31872

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1711 Guilford Ave* *Aug 19 1928* WARD)2-FULL NAME *Charles F. Jordan*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. *1711 Guilford Ave* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Margaret E. Jordan*6 DATE OF BIRTH (month, day, and year) *Aug 22 - 1890*

7 AGE

*37* YearsMonths *6*Days *27*If LESS than  
1 day, hrs.  
or min.*38*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Batham Steel*

(c) Name of employer

*Company*9 BIRTHPLACE (city or town)  
(State or country)*Baets Ind*

10 NAME OF FATHER

*Charles F. Jordan*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baets Ind*

12 MAIDEN NAME OF MOTHER

*Grace Melville*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baets Ind*

14

Informant  
(Address)*Mrs Ella Fenty*  
*1711 Guilford Ave*

15

Date

*MAR 21 1928**R. J. [Signature]*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mich 19, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mich 14, 1928*, to *Mich 17, 1928*,that I last saw him alive on *Mich 17, 1928*and that death occurred, on the date stated above, at *10, 30 P. M.*

The CAUSE OF DEATH\* was as follows:

*Fatty degeneration of heart*(duration) *2* yrs. mos. ds.CONTRIBUTORY  
(Secondary)*Apoplexy*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *No*

(Signed)

*Hugh Forsythe*, M. D.

3, 20, 1928 (Address)

*424 E. North Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Johnson Park*

UNDERTAKER

*Wm Cook*

DATE OF BURIAL

*3/21 1928*

ADDRESS

*502 E. North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31873

## CERTIFICATE OF DEATH

E 31873

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mersey Hospital St. 27th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Riels(a) RESIDENCE NO. 5311 Hamilton Ct St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19, 19287 AGE Years 2 years Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day \_\_\_\_\_ hrs. or 30 min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md.10 NAME OF FATHER Vernon C. Riels11 BIRTHPLACE OF FATHER (City or town) Balto. Md. (State or country)12 MAIDEN NAME OF MOTHER Mary A. White13 BIRTHPLACE OF MOTHER (city or town) Hamilton, Md. (State or country)14 Informant Mr. Vernon C. Riels (Address) 5311 Hamilton Court15 Filed \_\_\_\_\_, 19 \_\_\_\_\_ Registrar [Signature]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19/28 19 \_\_\_\_\_17 I HEREBY CERTIFY, That I attended deceased from 3/19/28, 19 \_\_\_\_\_, to 3/19/28, 19 \_\_\_\_\_, that I last saw him alive on 3/19/28, 19 \_\_\_\_\_, and that death occurred, on the date stated above, at 5:00 p.m.The CAUSE OF DEATH\* was as follows: Cerebral HemorrhageCONTRIBUTORY (duration) Unknown yrs. mos. ds. (Secondary) Prolonged labor

(duration) \_\_\_\_\_ yrs. mos. ds.

18 Where was disease contracted

if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? Clinical(Signed) J. E. Winstead, M. D., 19 \_\_\_\_\_ (Address) Mersey Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Hardman Army. March 19, 28

20 UNDERTAKER ADDRESS

John O. Mitchell & Sons 1900 Cedar St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31874

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *208 Locust and Cyprip-4* ST. WARD)

## 2-FULL NAME

*John Joseph Travers*(a) RESIDENCE NO. *208 Locust and* ST.

(Usual place of abode)

Length of residence in city or town where death occurred *27* yrs. *6* mos. *18* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

57 E 31874

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Aug 31-1900*

7 AGE

Years

Months

Days

*27**6**18*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Electrician*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Electro Mechanical Co.*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*Joseph A Travers*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md.*

12 MAIDEN NAME OF MOTHER

*Mary Nath*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md*

PARENTS

14

Informant (Address)

*Mrs Mary Wierner (Mother) 208 Locust and*

MAR 21 1928

P.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 18 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar. 17, 1928*, to *Mar. 18, 1928*, that I last saw him alive on *Mar. 18, 1928*, and that death occurred, on the date stated above, at *8:30 P. M.* The CAUSE OF DEATH\* was as follows:*Diabetic Coma*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos

ds.

(duration)

yrs.

mos

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Thos. J. Sevens* M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery*

UNDERTAKER

*Lilly & John Doe*

ADDRESS

*1000.40th St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31875

## CERTIFICATE OF DEATH.

E 31875

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1929 Mc Elderry* ST. *769* WARD)2-FULL NAME *John Tauber*(a) RESIDENCE. NO. *1929 Mc Elderry* ST. *6* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary Tauber*6 DATE OF BIRTH (month, day, and year) *Nov 27 1846*7 AGE Years *81* Months *2* Days *22* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *Don't Know*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Don't Know*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Mary Tauber Wife* (Address) *7929 Mc Elderry St.*15 *21 1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-20 1928*17 I HEREBY CERTIFY That I attended deceased from *1-1-28* 19 *3-20* 1928 to *3-19* 1928 that I last saw him alive on *3-19* 1928 and that death occurred on the date stated above, at *8-20* p.m.

The CAUSE OF DEATH\* was as follows:

*Causes of Death  
1. Live  
2. M. Cardiac Deletory*CONTRIBUTOR (Secondary) *Acute Cardiac Deletory*18 Where was disease contracted if not at place of death? *Germany*Did an operation precede death? *No* Date of *3-20*Was there an autopsy? *No*What test confirmed diagnosis? *Findings*(Signed) *John D. Murphy M.D.*Address *800 North 2nd St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Holy Redeemer Cemetery* DATE OF BURIAL *March 24 1928*20 UNDERTAKER *Lilly & Ziehl Inc.* ADDRESS *400 S. Hope St.*

E 31876

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 31876

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Sydenham Hospital 6-67*)

## 2-FULL NAME

*Evelyn Hall*

## (a) RESIDENCE NO.

*3012 Roseland Place*

(Usual place of abode)

St. Ward

Length of residence in city or town where death occurred *4* yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 Color or Race

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Feb. 22, 1922*

## 7 AGE

Years

Months

Days

If LESS than  
1 day.....hrs.  
or.....min..*6**1**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Schoolgirl*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

*Baltimore*

(State or country)

*Maryland*

## 10 NAME OF FATHER

*Fredrick Hall*

## 11 BIRTHPLACE OF FATHER (City or town)

*Boston*

(State or country)

*Mass.*

## 12 MAIDEN NAME OF MOTHER

*Catherine Flynn*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Baltimore*

(State or country)

*Maryland*

## 14

Informant  
(Address)*J. Fred Hall Father**3012 Roseland Place*

## 15 Filed

*2-27-28**1928*

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

*March 20, 1928*

## 17

1 HEREBY CERTIFY, That I attended deceased from

*Feb. 29, 1928, to March 20, 1928*that I last saw her alive on *March 20, 1928*and that death occurred, on the date stated above, at *110 p. m.*

The CAUSE OF DEATH\* was as follows:

*Whooping-cough*

(duration)

yrs.

mos.

da.

CONTRIBUTORY  
(Secondary)*Bronchopneumonia*

(duration)

yrs.

mos.

da.

## 18 Where was disease contracted

If not at place of death?

*at home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*

(Signed)

*J. R. Kinn*

M. D.

Mar. 23<sup>rd</sup> 1928 (Address)*Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*St. Catharine Cemetery Mar 21, 1928*

## 20 UNDERTAKER

ADDRESS

*Edmund W. Conklin 984 E Eager St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31877

## CERTIFICATE OF DEATH.

100-001  
E 31877

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 652 H. Hoffman Ward 17-24)2-FULL NAME Wm H. Hopley(a) RESIDENCE NO. 652 H. Hoffman Ward 17-24

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race colored 5 ~~Single~~ Married Widowed, or ~~Divorced~~, (write the word) Widower5a If ~~married~~, widowed, or divorced Widower (or) Widow6 DATE OF BIRTH (month, day, and year) Unknown 18817 AGE 47 Years — Months — Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) West Indies (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Edith Brown (Address) 652 H. Hoffman St15 Filed 1928 10-28 Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)(Thereon and from the evidence obtained by said Inquiry Request, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumo. Pneumonia (Duration) 2 yrs. 1 mos. 2 ds.CONTRIBUTORY Coronary (Secondary)Mar 79/28 (duration) 9 yrs. 6 mos. 1 ds. (Coroner) M. D.79/28 (Address) 143 W. Bay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt. Auburn Mar 21, 2820 UNDERTAKER John H. Toadum ADDRESS 1027 Wood Hill



Burial extended to 3/22/28 U.S.E.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31878

## CERTIFICATE OF DEATH

REGISTERED NO.

E 31878

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 419 S. Collington Ave. 1 Ward)2-FULL NAME Ursula Eva Brown(a) RESIDENCE NO. 419 S. Collington Ave. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 16 mos. 16 ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3rd 19247 AGE Years 4 Months 16 Days 17 IF LESS than 1 day hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Balto. clld.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. clld. (State or country)10 NAME OF FATHER Frank J. Brown11 BIRTHPLACE OF FATHER (City or town) Balto. clld. (State or country)12 MAIDEN NAME OF MOTHER Bertha V. Olsen13 BIRTHPLACE OF MOTHER (city or town) Balto. clld. (State or country)14 Informant Frank J. Brown Father (Address) 419 S. Collington Ave.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20th 192817 HEREBY CERTIFY, That I attended deceased from 3-19-28 to 3-20-28that I last saw him alive on 3-19-28 and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH\* was as follows:

(Measles) & 2  
not sure

CONTRIBUTORY (Secondary)

18 Where was disease contracted

If not at place of death? underDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? for diph.(Signed) Frank J. Brown(Address) 419 S. Collington Ave.

State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery 3/22/28

20 UNDERTAKER

Lilly & Zeller Inc. ADDRESS 1000 N. ...

Very important. See instructions on back of certificates.

MAR 21 1928

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31879

## CERTIFICATE OF DEATH

E 31879

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 737 ForrestSt. 10-15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Hamill(a) RESIDENCE NO. 737 Forrest

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 1 da.How long in U. S. if of foreign birth? 19 yrs. 2 mos. 28 da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced. (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Not known

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min..

about 72

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md

10 NAME OF FATHER

Mr. Nease

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not known

14

Informant (Address)

Mr. Christina Snyder  
737 Forrest St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 191928

17

I HEREBY CERTIFY, that I attended deceased from

March 18 1928, to March 19 1928,that I last saw her alive on March 19 1928and that death occurred, on the date stated above, at 5:20 PM

The CAUSE OF DEATH\* was as follows:

Cancer of Liver

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY

(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) John J. [Signature] M. D.(Address) 1834 St. Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Cross CemeteryMarch 22 1928

20 UNDERTAKER

ADDRESS

Henry [Signature]1301 E. [Signature]

Very Important - See Instructions on Back of Certificate.

AR 21 1928

Registrar

E 31880

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 31880  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *14* WARD)

## 2-FULL NAME

*Rev. Fr. William Jewes*

## (a) RESIDENCE NO.

(Usual place of abode)

*St James Rectory* ST. *14* WARDLength of residence in city or town where death occurred *68* yrs. *5* mos. *24* ds.How long in U. S., if of foreign birth? *22* yrs. *10* mos. *14* ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Sept. 22, 1859*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*68**5**26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Religious*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Arch. & J. J. Jones Church*

(c) Name of employer

*Redemptorist Priest*

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

## 10 NAME OF FATHER

*Joseph Jewes*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md*

## 12 MAIDEN NAME OF MOTHER

*Elizabeth Roper*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md*

## 14

Informant (Address)

*Rev. Fr. William Jewes*

## 15

Filed

*21 1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*3-18 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 10, 1928* to *March 18, 1928*that I last saw him alive on *March 18, 1928* and that death occurred, on the date stated above, at *9.33 P. M.*

The CAUSE OF DEATH\* was as follows:

*Chr. Myocarditis*

(duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

*Acute Cardiac decompensation*

(duration) yrs. mos. da.

## 18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *H. Lawrence Fabney, M. D.*1928 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*Holy Redeemer Cemetery**Mar 20 1928*

## UNDERTAKER

## ADDRESS

*Henry Jacobson**1301 E. Eager St*

E 31881

## CERTIFICATE OF DEATH.

E 31881

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

Length of residence in city or town where death occurred 40 yrs.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY That I took charge of the remains described above, held an

(Inquest, autopsy, inquiry.)

thereon and from the evidence obtained by said

And that said deceased came to death

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signe)

1928 (Address)

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

MAR 21 1928

Registrar

Edward Bryson

arlene et



## HEALTH DEPARTMENT—CITY OF BALTIMORE

31882

## CERTIFICATE OF DEATH.

91E 31882

1-PLACE OF DEATH 42 Albemarle St Balto. Md.

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Weinshenker.

(a) RESIDENCE NO. 42 Albemarle St

ST.

WARD 407

(Usual place of abode)

Length of residence in city or town where death occurred 40+ yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

White.

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Boris Weinshenker.

6 DATE OF BIRTH (month, day, and year)

1863

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

65

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Russia

10 NAME OF FATHER Abraham Scherman

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Bessie Heller

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Russia

14

Informant  
(Address)B. Weinshenker  
42 Albemarle St

APR 21 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19 1928

17

I HEREBY CERTIFY, That I attended deceased from

1926, 1926, to 3/18 1928,

that I last saw her alive on 3/18 1928

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Generalized Arterio Sclerosis  
Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY Pulmonary Edema  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical observation

(Signed)

Leon Weidman, M. D.  
3/19/28 (Address) 420 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALHebrew Herring Run  
10 UNDERTAKER

DATE OF BURIAL

3/21, 28

ADDRESS 1127

101 Lumsden + Bro E Balto St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31883

## CERTIFICATE OF DEATH.

31✓ E 31883

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1106 Duke St., 3-5 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1106 Duke St., \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

male colored single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.43

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

laborer 40

## 9 BIRTHPLACE (city or town)

(State or country)

20

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)1106 Duke  
Edmund Brizon

## 15

Filed

1106 Duke  
Edmund Brizon  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 192817 I HEREBY CERTIFY that I took charge of the remains described above, held an  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said  
and that said deceased came to death  
on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Pul. TBCONTRIBUTORY  
(Secondary)Mar 20/28 143 No 3 way

E 31884

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31884

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Square Hospital*  
 CITY OF BALTIMORE: (No. *Calhoun + Sayette* ST. *13-52* WARD) REGISTERED NO. *117*  
 2-FULL NAME *Thomas Edward Reilly*  
 (a) RESIDENCE NO. *815 W. 36th* ST., WARD *117*  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *25* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced  
 (or) WIFE of *Emma Virginia Reilly*

6 DATE OF BIRTH (month, day, and year) *June 7, 1862*  
 7 AGE Years *65* Months *9* Days *11* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *night watchman*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *fb*  
 (c) Name of employer

9 BIRTHPLACE (city or town) *Providence, R.I.*  
 (State or country)

10 NAME OF FATHER *Thomas Reilly*  
 11 BIRTHPLACE OF FATHER (city or town) *Unknown*  
 (State or country)  
 12 MAIDEN NAME OF MOTHER *Kathleen Connelly*  
 13 BIRTHPLACE OF MOTHER (city or town) *Unknown*  
 (State or country)

14 Informant *wife Mrs. Emma E. Reilly*  
 (Address) *815 W. 36th St.*

15 Filed *21 1928* REGISTRAR *W. J. Jones, Jr.*  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 18 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Mar. 14*, 1928, to *Mar. 18*, 1928, that I last saw him alive on *Mar. 18*, 1928, and that death occurred, on the date stated above, at *11:30 P. M.*

The CAUSE OF DEATH\* was as follows:

*Peritonitis*

(duration) yrs. mos. *5* ds.  
 CONTRIBUTORY (Secondary) *Probable embolus*  
 (duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *Yes* Date of *Mar. 15, '28*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Elizabeth B. Shuman, M.D.*

19 (Address) *Franklin Sq. Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Stroud Ridge Md 21 1928*

20 UNDERTAKER *Horace F. Burgee* ADDRESS *363 Kells Rd.*

E 31885

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

22 yrs.

4 mos.

12 ds.

How long in U. S., if of foreign birth?

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

white

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Vernon Spicer

6 DATE OF BIRTH (month, day, and year)

Nov. 7-1905

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

22

4

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Edward Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Conroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Vernon Spicer - 418 E. 21st

15

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1928

17

I HEREBY CERTIFY, That I attended ceased from March 18, 1928, to March 19, 1928, that I last saw her alive on March 19, 1928, and that death occurred, on the date stated above, at 11:10A m.

The CAUSE OF DEATH\* was as follows:

Chr. Myocarditis - Ectodocarditis -

(duration) yrs. mos. ds.

CONTRIBUTORY Acute Cardiac Decompensation (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis? Clinical

(Signed) H. Lawrence Fahnestock, M. D.

19 (Address) St. Joseph Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

1 Woodlawn March 22 1928

UNDERTAKER ADDRESS

Grace H. Burgee 343 Fellows Rd.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31886

## CERTIFICATE OF DEATH.

90 E 31886

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 N. Lexington St., 76 Ward)2-FULL NAME Mary Jane Sheppard(a) RESIDENCE NO. 1118 N. Lexington St., 76 Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

Cold

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

about 70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

PARENTS

14

Informant

(Address)

Shelley Hall121 N. Carlton St.

15 Filed.....

19

MAR 27 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 19, 1928

17

I HEREBY CERTIFY That I took charge of the

remains described above, held a

Inquiry

thereon and from the evidence obtained

Inquiry

and that said deceased came

Ther

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation  
(duration) agency

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(Signed)

Thos. B. Norton

M. D.

(Address)

19 N. Curtis Bay, Balt.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospital, Institutions, Transients, or Recent Residents.)

At place

of death

yrs.,

mos.,

ds.

In the

yrs.,

mos.,

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt Zion CemeteryMar 22 1928

20 UNDERTAKER

ADDRESS

Mrs. Kate R WilliamsA. Schreder

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31887

## CERTIFICATE OF DEATH.

E 31887

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 Bylburn Ave ST. 3 WARD)2-FULL NAME Elsie M. Leach(a) RESIDENCE No. 229 Bylburn Ave ST. 3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs.  mos.  ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Horace N. Leach or) WIFE of6 DATE OF BIRTH (month, day, and year) Aug 22-1895

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32626

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phila. Pa. (State or country)10 NAME OF FATHER Samuel Yost11 BIRTHPLACE OF FATHER (city or town) Pa. (State or country)12 MAIDEN NAME OF MOTHER Margaret A.13 BIRTHPLACE OF MOTHER Pa. (State or country)

14

Informant (Address) Horace N. Leach 229 Bylburn Ave

15

Filed 21 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19 19 28

17

HEREBY CERTIFY, That I attended deceased from Mar 15, 19 28, to Mar 19, 19 28that I last saw her alive on March 19, 19 28and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. mos. ds. 5CONTRIBUTORY (Secondary) Myocardial Infarction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John S. Dubert M.D., 19 (Address) 4757 Fair Heights

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MORAL

Phila. Pa.Mar 20 19 28

UNDER TAKER

Wm J. Pickner & Sons

ADDRESS

N.Y. Pa.

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31888

E 31888

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *318 N. Second St Brooklyn* ST., *75* WARD)2-FULL NAME *John A Schwabland*(a) RESIDENCE NO. *318 N. Second St Brooklyn* ST., *75* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 26<sup>th</sup> 1928*7 AGE Years *9* Months *23* Days *24* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *Jos. Schwabland*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *Bertha Weakland*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Prussia*14 Informant *Jos. Schwabland* (Address) *318 N Second St*15 Filed *2-1-1928* 19 *2-1-1928* Registrar *R. R. K.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-20<sup>th</sup> 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar 17, 1928* to *Mar 20, 1928* that I last saw h alive on *Mar 20, 1928* and that death occurred, on the date stated above, at *4:10 P* m.

The CAUSE OF DEATH\* was as follows:

*Measles + Broncho Pneumonia* (duration) yrs. mos. *5* ds.CONTRIBUTORY (Secondary) *Exhaustion* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *R. H. Campbell* M. D.19 *Mar 28* (Address) *1644 Hancock*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Cedar Hill*

DATE OF BURIAL

*3-21 1928*

20 UNDERTAKER

ADDRESS

*303 N. 115<sup>th</sup> St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31889

## CERTIFICATE OF DEATH.

E 31889  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1034 N Mount St. 16-22 Ward)2-FULL NAME Josue Wilson(a) RESIDENCE NO. 1034 N Mount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♂ 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 23 - 19277 AGE Years Months Days 27 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore10 NAME OF FATHER Joe. Wilson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa12 MAIDEN NAME OF MOTHER Fannie Ward

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14

Informant (Address) Fannie Wilson  
1034 N Mount15 Filed 21 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 192817 I HEREBY CERTIFY that I took charge of the remains described above, held an. Inquiry (Inquest, autopsy or inquiry.)the record and from the evidence obtained by said Inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cas. Bronchitis(duration) yrs. mos. ds. 2

CONTRIBUTORY (Second)

Heart (duration) yrs. mos. ds. 111/20 (Address) 143 N Bmwy19 (Address) 143 N Bmwy

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL M. Zion Date of Burial Nov 21 192820 UNDERTAKER Sam H. ChaseADDRESS 1400 Mch



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31890

## CERTIFICATE OF DEATH.

1002  
16 E 31890

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Shackle ST., 2-4 WARD)

## 2-FULL NAME

Peter Witkowski

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1610 Shackle

(Usual place of abode)

ST., 2 WARD

Length of residence in city or town where death occurred 10 yrs. mos.

ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Peter Witkowski

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

69

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Laborer 040

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Poland

## 10 NAME OF FATHER

John Witkowski

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

## 14

## Informant (Address)

Walter Witkowski

## Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 10, 1928 to Mar 10, 1928.

that I last saw him alive on Mar 10, 1928.

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH\* was as follows:

Dysentery

(duration) yrs. mos 20 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

## 18 Where was disease contracted if not at place of death?

at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hematology of Blood

(Signed) J. J. Witkowski, M. D.

20 3, 1928 (Address) 2042 East Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Holy Rosary March 22 1928

## 20 UNDERTAKER

## ADDRESS

F. W. Gzowski 1930 Eastern Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31891

## CERTIFICATE OF DEATH.

47 E 31891

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 West 27th. St.

ST. 11-19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Pleitner

(a) RESIDENCE No. Montreal Apts. Mt. Royal Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C.H. Pleitner

6 DATE OF BIRTH (month, day, and year) Nov. 2 1851

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
76 4 17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Frank Dettman

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Tena Rutiger.

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Frank E. Pleitner.

(Address) Montreal Apts W. Mt. Royal Ave.

15 Filed 21 1928 G. S. J. Jones, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1928.

17

I HEREBY CERTIFY, That I attended deceased from March 1<sup>st</sup>, 1926, to March 19<sup>th</sup>, 1928, that I last saw her alive on March 19<sup>th</sup>, 1928

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of breast

(duration) 2 yrs. 19 mos. 19 ds.  
CONTRIBUTORY Exhaustion  
(Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? none

(Signed) Charles H. Fisher, M. D.

March 20, 1928 (Address) 2406 Pa. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery

3/22 1928

20 UNDERTAKER

ADDRESS

Chas. F. Evans &amp; Son 118 W. Mt. Royal Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31892

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #103 N. Port St.

ST. 6-10 WARD)

2-FULL NAME Helen Barnes

(a) RESIDENCE NO. #103 N. Port St.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred Life

mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/29/27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2		20	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City  
(State or country)

10 NAME OF FATHER Chas. J. Barnes

11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Augusta Goette

13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)14 Informant Augusta Barnes  
(Address) 103 N. Port St.

15 R 21 1928 E. J. Jones, K. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 1928

I HEREBY CERTIFY, That I attended deceased from  
That 13, 1928 to That 20, 1928,  
that I last saw her alive on Mar 20, 1928,  
and that death occurred, on the date stated above, at 7:05 A.M.  
The CAUSE OF DEATH\* was as follows:

Bunches Pneumonia

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Trinity Cem

DATE OF BURIAL

3/21/28,

ADDRESS

20 UNDERTAKER

Philip Herwig 2016 Orleans St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31893

## CERTIFICATE OF DEATH.

46 E 31893

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #12 S. Robinson St.

ST. 1-2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora May Preston

(a) RESIDENCE NO. #12 S. Robinson St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds.

How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. H. Preston

6 DATE OF BIRTH (month, day, and year) June 1st. 1871

7 AGE Years 56 Months 9 Days 18 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Randolph Co. N.C.

10 NAME OF FATHER Wm. P. Osborne

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Delana Hinshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Robt. H. Preston

(Address) 12 S. Robinson St.

15 Filed 1913 REGISTRAR R. H. Jones, R. H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1926 to Mar 20 1928, that I last saw her alive on March 20 1928, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Cervix Uteri

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic (Signed) Stander M. Leiby, M. D.

, 19 (Address) 1609 Linden Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Fort Lincoln Cem.

DATE OF BURIAL

3/23/28

20 UNDERTAKER

Philip Henry 2016 Delaware St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31894

## CERTIFICATE OF DEATH

129 ✓  
E 31894  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 5309 James Ave. Hamilton Ward)

## 2-FULL NAME

Mrs. Emma Jane Dorsey

## (a) RESIDENCE NO.

5509 James Ave. (Hamilton Ward)

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 70 yrs. mos. da. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced  
HUSBAND or  
(or) WIFE of

James P. Dorsey

## 6 DATE OF BIRTH (month, day, and year)

Aug 18. 1849

## 7 AGE

Years

78

Months

7

Days

2

IF LESS than  
1 day hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore Co. Md

(State or country)

## 10 NAME OF FATHER

Samuel Logan Hall

## 11 BIRTHPLACE OF FATHER (City or town)

Becil Co. Md.

(State or country)

## 12 MAIDEN NAME OF MOTHER

Elija Tyson

## 13 BIRTHPLACE OF MOTHER (city or town)

Becil Co. Md.

(State or country)

## 14

Informant  
(Address)Bessie Dorsey Tylor  
5509 James Ave.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

March 20. 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 12. 1928, to March 20. 1928,

that I last saw her alive on March 18. 1928,

and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration)

yrs. 8

mos. 1

da. 1

## CONTRIBUTORY

(Secondary)

Myocarditis

(duration)

yrs. 1

mos. 1

da. 1

## 18 Where was disease contracted

if not at place of death? ✓

Did an operation precede death? No

Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed)

George C. Shannon, M. D.

3/20. 1928 (Address)

700 Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mount Carmel Cem

March 22 1928

## 20 UNDERTAKER

George J. Smith

ADDRESS 1532  
Hollins St

Very important. See instructions on back of certificates.

PARENTS

MAR 21 1928

Registrar

E 31895

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31895

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Pearl

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 118 Pearl

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 21, 1865

7 AGE

Years

Months

Days

LESS than 1 day, hrs. or min.

62

02

4

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John W Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Lucinda Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Mrs Emma V. Marshall

1706 Eutaw Place

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1928

17

I HEREBY CERTIFY, That I attended deceased from

Dec 30, 1925, to March 20, 1928.

that I last saw him alive on March 14, 1928.

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage with left hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Bronchial asthma

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed)

Chas. J. Keller, M. D.

19 (Address) 222 W. Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

March 22 1928

20 UNDERTAKER

ADDRESS

George J. Smith

153 L Hollins

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31896

## CERTIFICATE OF DEATH

135 ✓  
REGISTERED E 31896

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Md. Gen Hosp.* 28-64 St. *28-64* Ward)2-FULL NAME *Charles J. Gettier*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *5201 Gwyn Oak Ave* St. *28-64* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced (write the word)

*Male White**Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *1863*

## 7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min.. *65*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md*  
(State or country)10 NAME OF FATHER *John L. Gettier*11 BIRTHPLACE OF FATHER (City or town) *Md*  
(State or country)12 MAIDEN NAME OF MOTHER *Wise*13 BIRTHPLACE OF MOTHER (city or town) *Unknown*  
(State or country)

## 14

Informant *Hospital Records*  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 20, 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from *Feb 11, 1928, to March 20, 1928*that I last saw him alive on *March 20, 1928*and that death occurred, on the date stated above, at *2 21 A. M.*

The CAUSE OF DEATH\* was as follows:

*Hypertrophic Prostate*CONTRIBUTORY *Unknown*  
(Secondary)(duration) *Unknown* yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death? *Unknown*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Geo. Thompson* M. D., 19 *1928*(Address) *11723 M. D.*

\*State the Disease Causing Death. In deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

*Greenmount Cemetery Apr 23rd 1928*  
*Debs and Gore 11723 M. D.*

Very important. See instructions on back of certificates.

15 Filed

MAR 21 1928

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31897

## CERTIFICATE OF DEATH.

E 31897

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 441 W. Henrietta St. St. 21-31 Ward)

## 2-FULL NAME

Guy Hurley. (C)

## (a) RESIDENCE NO.

441 W. Henrietta St.

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Male.

Colored

Married.

6a If married. ~~XXXXXXXXXXXX~~  
HUSBAND of  
~~XXXXXXXXXXXX~~

Edna Hurley. (C)

## 6 DATE OF BIRTH (month, day, and year)

Do not know.

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

32

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Calvert Co. Md.

## 10 NAME OF FATHER

Joseph H. Hurley. (C)

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Calvert Co. Md.

## 12 MAIDEN NAME OF MOTHER

Maggie Freeman. (C)

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Calvert Co. Md.

## 14

Informant  
(Address)Susie Purvey. (C) sister.  
441 W. Henrietta St.

## 15 Filed

AR 21 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 19, 1928

## 17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, au-  
topsy or inquiry.) find that said deceased came to its death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) W. H. Purvey M. D.  
(Coroner)

3/19 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR Date of Burial

W. H. Purvey March 22, 1928

## 20 UNDERTAKER

ADDRESS

W. H. Purvey 1400 Mosher





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31899

## CERTIFICATE OF DEATH.

1.E 31899

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 17-76 Ward)2-FULL NAME Mary Terry(a) RESIDENCE NO. 705 George

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female

Negro

Married

5a If married, widowed, or divorced  
HUSBAND of

(or) WIFE of

Grand Terry

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....

At home

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

Balto. Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Unknown

14

Informant  
(Address)

Hospital Record

15 Filed \_\_\_\_\_ 19 \_\_\_\_\_

Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

192

8

March 16

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry

and that said deceased came to her death

(topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Post-partum Hemorrhage.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner)

M. D.

3/16/28 (Address) 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

In the

of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial

Burial

UNDERTAKER

Funeral Home

3/20/28

ADDRESS

916 Paaz

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31900

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 &amp; Biddle

2. FULL NAME

James Rankford

(a) RESIDENCE NO.

(Usual place of abode)

1903 &amp; Biddle

Length of residence in city or town where death occurred

14

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.

WARD)

ST.

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

M

C

Married

5a If married, widowed, or divorced

HUSBAND of

Ellen Rankford

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

approx 33

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Bethlehem Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N.C.

10 NAME OF FATHER

John Rankford

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N.C.

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.C.

14

Informant (Address)

Ellen Rankford wife  
1903 & Biddle

15

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1928

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1928, to March 19, 1928, that I last saw him alive on March 19, 1928, and that death occurred, on the date stated above, at 7<sup>50</sup> A. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Acute Nephritis &amp; Anemia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical

(Signed)

#10 1928

(Address)

1429 E Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31901

## CERTIFICATE OF DEATH.

E 31901

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 S. East ave. ST. 10-7 WARD)

## 2-FULL NAME

Thos. O. Daneke Sr.

(a) RESIDENCE NO. 307 S. East ave ST. 10-7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 21 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1928

17

I HEREBY CERTIFY, That I attended deceased from

3/13 1928, to 3/17 1928,

that I last saw him alive on 3/17 1928,

and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. H. M. D.

3/19, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

3/21/ 1928

ADDRESS 3099

E. Balt. H.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31902

## CERTIFICATE OF DEATH.

46 E 31902

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balt. City Hospital - 20* WARD)2-FULL NAME *Carrie Lillman TILLMAN*(a) RESIDENCE NO. *11 W. Lafayette* ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Red* 5 Single, Married, Widowed, or Divorced, (write the word) *Divorced*5a If married, widowed, divorced, HUSBAND of (or) WIFE of *not known*6 DATE OF BIRTH (month, day, and year) *?*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *48 7 7*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)10 NAME OF FATHER *John Daniels*11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country)12 MAIDEN NAME OF MOTHER *Mary*13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)14 Informant *Hospital Record* (Address)15 *C. S. HARRIS, JR., M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-20-1928*17 I HEREBY CERTIFY, That I attended deceased from *3-16*, 19*28*, to *3-20*, 19*28*.that I last saw him alive on *3-20*, 19*28*.and that death occurred, on the date stated above, at *7:30* m.

The CAUSE OF DEATH\* was as follows:

*Coronary Artery**Unknown* mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Exam*(Signed) *B. A. Green* M. D.19 (Address) *Balt. City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

*Stevensonville Md.*20 UNDERTAKER *Est B Harb 115 E West*

ADDRESS

21 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31903

## CERTIFICATE OF DEATH.

31 E 31903

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *719 N. E. den*ST. *10-13* WARD)2-FULL NAME *Hattie Staton*(a) RESIDENCE NO. *719 N. E. den*

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *4* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F*4 COLOR OR RACE *C.*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of or WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *1900*

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

*28*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) (State or country) *Washington N.C.*10 NAME OF FATHER *Joseph Edwards*

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Wash. N.C.*12 MAIDEN NAME OF MOTHER *Hattie Gaynor*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Wash. N.C.*

14

Informant (Address) *Lucille Edwards 719 N. E. den St.*

15

Filed *1928*Registers *Robert H.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 19 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Dec 27*, 19 *27*, to *March 19*, 19 *28*, that I last saw her alive on *March 18*, 19 *28*, and that death occurred, on the date stated above, at *5 A. m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Phthisis*(duration) \_\_\_\_\_ yrs. *3* mos. \_\_\_\_\_ ds.CONTRIBUTORY (Secondary) *Pulmonary Edema*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Physical*(Signed) *R. H. Gray*

M. D.

3/20/28 (Address) *1429 E. Howard St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Washington N.C.*

DATE OF BURIAL

*3/21 1928*20 UNDERTAKER *Byron Knight 1218 N. E. den St.*

ADDRESS

E 31904

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31904

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5-8 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Johnson(a) RESIDENCE No. 512 East Or William Johnson WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?7 AGE Years Months Days If LESS than 1 day, hrs. or min. 49

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER John Johnson11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER See13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant (Address) Records15 File 1928 1928 RECORDED INDEXED JOHN J. JONES, R. RRN Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 12, 1928, to Mar. 14, 1928.that I last saw him alive on Mar. 14, 1928,and that death occurred, on the date stated above, at 12:40 P.m.

The CAUSE OF DEATH\* was as follows:

Solar pneumonia,(duration) yrs. mos. ds. 10

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General + Sero.(Signed) E. J. Jones, M.D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sacred Heart3/21 1928

UNDERTAKER

ADDRESS

J. J. Foley Sons1318 Light St

E 31905

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31905

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3-5 ST., 3-5 WARD)REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jenny A. Burnsor Kenerson(a) RESIDENCE NO. 1000 N. Calverman St.WARD 3

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced, (write the word) <u>Widowed</u>
----------------------	---------------------------------	---

5a If married, widowed, or divorced  
HUSBAND of ?  
(or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>67</u>			

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Massachusetts10 NAME OF FATHER David

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New Hampshire12 MAIDEN NAME OF MOTHER Delem

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14

Informant  
(Address) Records

15

File 1928Registrar APN

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 10, 1928 to Mar. 17, 1928  
that I last saw him alive on Mar. 17, 1928and that death occurred, on the date stated above, at 11:00 A. m.

The CAUSE OF DEATH\* was as follows:

hepatitis - chronic interstitial  
arteriosclerosis  
hypertension(duration) yrs. 6 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? ?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sub.(Signed) C. Holmes Burgh M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL  
Woodlawn Cemetery

DATE OF BURIAL

3/21/1928

20 UNDERTAKER

ADDRESS

1400 Ave



E 31906

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31906

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2328 N. Fayette St* ST. *20-69* WARD)2-FULL NAME *Julia Ann Shields*(a) RESIDENCE No. *2328 N Fayette*

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Married*

5a If married, widowed, or divorced

(or) WIFE of

*Jefferson Shields*

6 DATE OF BIRTH (month, day, and year)

*Sept 13 - 1864*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*63**6**3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House Wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at Home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Md*

10 NAME OF FATHER

*Patrick Whalen*

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md*

12 MAIDEN NAME OF MOTHER

*Mary Whalen*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md*

14

Informant (Address)

*Mr Jefferson Shields 2328 N Fayette St*

15

Filed

Pro

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/20 - 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*3/18 - 1928 to 3/20 - 1928*

that I last saw him alive on

*3/19 - 1928*

and that death occurred, on the date stated above, at

*6 A m.*

The CAUSE OF DEATH\* was as follows:

*Arterial Sclerosis hypertension*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Stenoplegia (right)*(duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*What test confirmed diagnosis? *High Blood pressure*(Signed) *Charles A. Cahan*, M. D.(Address) *2105 N Calte St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St Peter's Cemetery**May 23, 1928*

UNDERTAKER

ADDRESS

*W. Marshall 5539 Bell Rd*

E 31907

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31907

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3-W-mt. Vernon Pl. ST. 11-74 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Lucas Hurst(a) RESIDENCE No. 3-W-mt. Vernon Pl. ST. 11-74 WARD Resident

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 19 ds.How long in U. S., if of foreign birth? 68 yrs. 4 mos. 19 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of William B. Hurst6 DATE OF BIRTH (month, day, and year) about Nov-1-1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

about 68419

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland10 NAME OF FATHER E. Ridgely Baer

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.12 MAIDEN NAME OF MOTHER Virginia Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Maryland

14

Informant (Address)

Wm. B. Hurst Jr. (son) 3-W-mt. Vernon Pl.

15

Filed

19

HAMPSON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1928

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1928, to March 20, 1928, that I last saw him alive on March 20, 1928, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH\* was as follows:

Grippe Broncho Pneumonia & Septicemia(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lucy M. G. Smith, Jr. M. D.19 (Address) 2422 Biddle St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Smalltown Cemetery Mar 22 1928  
Stewart Howard 108 W. North

E 31908

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31908

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2433 Calverton Heights Ave. WARD)

## 2-FULL NAME

Sarah B. Rohrbaugh

## (a) RESIDENCE NO.

2433 Calverton Heights

(Usual place of abode)

Length of residence in city or town where death occurred

10 yrs.

- mos.

- ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Rohrbaugh

## 6 DATE OF BIRTH (month, day, and year)

Feb. 25, 1862

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66024

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Maryland

## 10 NAME OF FATHER

Thomas J. Abbott

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Rebecca Stansbury

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

## 14

Informant (Address)

Rebecca B. Rohrbaugh, 2433 Calverton Heights Ave.

## 15

Filed

MAR 21 1928

HARRISON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 25, 1928, to March 20, 1928,that I last saw her alive on March 19, 1928,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis with decompensation(duration) - yrs. 3 mos. - ds.CONTRIBUTORY Chronic nephritis,

(Secondary)

(duration) - yrs. 3 mos. - ds.

## 18 Where was disease contracted

If not at place of death?

so not knownDid an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Clinical findings(Signed) Maurice E. Shamer, M. D.

3300 N. Mott St. , 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Emory, Balto. Co.March 23, 1928

## 20 UNDERTAKER

E. Leroy Stiffler

## ADDRESS

1256 North Ave.

E 31909 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital 26-37* St. *Ward*)

2-FULL NAME

*Freddie Fletcher*

(Residence in Baltimore: No. *1016*)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE.

*Black*

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH.

(Month) (Day) (Year)

7-AGE.

*60*

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*N. K. 687*

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed *1928*

*HAMPSON JONES, K. D.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Mar 13*

(Month) (Day) (Year)

17-

I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*Bronchial Pneumonia*

(Duration) yrs. .... mos. .... ds.

CONTRIBUTORY CAUSES.

*W. J. G. 1016*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*PUBLIC CEMETERY*

20-UNDERTAKER,

*Commissioner of Health*

ADDRESS

*MAR 21 1928*



E 31910

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31910

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 532 71 Gilman

## 2-FULL NAME. Harriet Heath

(a) Residence No. 532 71 Gilman

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

St.

Ward

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-Single,

Married,

Widowed,

or Divorced,

(Write the word)

Widowed

6a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of

Widow

6-DATE OF BIRTH (month, day and year)

Unknown

7-AGE,

65

yrs.

mos.

ds.

If LESS than 1 day.

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work

Lawress

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Washing clothes

(c) Name of employer.

Maryland

9-BIRTHPLACE (city or town;  
(State or Country),

Maryland

PARENTS.

10-NAME OF  
FATHER,

David Miles

11-BIRTHPLACE  
OF FATHER (city or town)  
(State or Country),

Maryland

12-MAIDEN NAME  
OF MOTHER,

Leticia Thompson

13-BIRTHPLACE  
OF MOTHER (city or town)  
(State or Country),

Maryland

14-

(Informant)

Mrs. Sarah Brooks Jones

(Address)

532 71 Gilman

15-

Filed

1928

C. HAMMOND JONES, R. D.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

March 19 1928

17- I HEREBY CERTIFY, That I attended deceased from

Feb 28 1928 to March 19 1928

that I last saw her alive on March 18 1928

and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH was as follows:

Hepatitis Interstitial

(Duration) yrs. 0 mos. 20 ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. 0 mos. 0 ds.

18-Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed)

John C. Stewart

M. D.

19

(Address)

704 W. Lafayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL

Mt. Auburn Cemetery

DATE OF BURIAL,

Mar 25 1928

20-UNDERTAKER,

Mrs. Kate R. Williams

ADDRESS

3224

Schweden St.

E 31911

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31911

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 14-70 WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

2-FULL NAME Mary Brown(a) RESIDENCE NO. 1401 Bayview Ave WARD \_\_\_\_\_  
 (Usual place of abode)Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed,  
or Divorced, (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?7 AGE Years Months Days If LESS than  
1 day, hrs.  
or min. 58

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Saleswoman(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Maryland10 NAME OF FATHER ?11 BIRTHPLACE OF FATHER (city or town)  
(State or country) ?12 MAIDEN NAME OF MOTHER Sarah J. Jones13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Virginia

14

Informant  
(Address) Records

15

21-1928

G. HAMMOND JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/1928

I HEREBY CERTIFY That I attended deceased from  
Mar. 14, 1928, to Mar. 17, 1928  
 that I last saw him alive on Mar. 17, 1928  
 and that death occurred, on the date stated above, at 0:00 A.M.  
 The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic & acute  
arteriosclerosis  
Hypertension

(duration) yrs. 7 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? ?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? General & Sub(Signed) C. J. Williams, M.D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALW. H. Auburn Cemetery

20 UNDERTAKER

J. M. Jones

DATE OF BURIAL

Mar 22 1928ADDRESS 1234  
Edney St.

2E<sup>2</sup> 31912

(Harper)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

+ 8E 31912

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

## 2-FULL NAME

Emily Harper

ST. 79 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

4-Arqueline, Fla

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST. WARD

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Child

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

2-29-24

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

X

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Em

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Georgia

## 10 NAME OF FATHER

H. Grady Harper

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ga

## 12 MAIDEN NAME OF MOTHER

Emily Wansley

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ga

## 14

Informant (Address)

Records

## 15

Filed

1928

19

HAMPSON

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 20 1928

## 17

I HEREBY CERTIFY, That I attended deceased from Mar 19 1928, to Mar 20 1928,

that I last saw her alive on Mar 20 1928,

and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia - Right  
Cerebral Hemorrhage  
Gleoma, benign

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? Yes Date of March 20, 1928

Was there an autopsy? No

What test confirmed diagnosis?

Clinical operative

(Signed)

F. D. Coman

M. D.

3-20-1928 (Address)

Johns Hopkins

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

BURYAL

Washington Ga.

## DATE OF BURIAL

3/21/28

## 20 UNDERTAKER

Harper &amp; Son Inc

## ADDRESS

4401 Brady

E 31913

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. WARD)

## 2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

30rs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Wella Zelenas

6 DATE OF BIRTH (month, day, and year)

Jan. 29, 1877

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

51

50

1

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Tailor

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Customs

(c) Name of employer

Katz, Sons

9 BIRTHPLACE (city or town)  
(State or country)

Lithuania

10 NAME OF FATHER

J. J. Lewis

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Lithuania

12 MAIDEN NAME OF MOTHER

don't know

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Lithuania

14

Informant  
(Address)Mrs. Frank Lewis  
846 Woodward St.

15

File

1928 C. HANCOCK JONES, R. D.  
R. H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 19, 1928

17

I HEREBY CERTIFY, that I attended deceased from  
Oct 1, 1927, to March 19, 1928that I last saw him live on March 19, 1928  
and that death occurred, on the date stated above, at 7-pm

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY  
(Secondary)

analysis right side

(duration) yrs. mos. — ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) M. B. Friedman, M.D.

322 1928 (Address) 682 Madison St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Holy Cross Cemetery

Mar 24, 1928

20 UNDERTAKER

ADDRESS

Charles B. Kuchan

637 S. Paca St.



E 31914

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31914

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4310 Walnut Ave.

2-FULL NAME Eliza Jane La Motte,

(a) RESIDENCE No. 4310 Walnut Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Widow

5a If married, widowed, or divorced  
HUSBAND or  
(or) WIFE of

Geo. W. La Motte,

6 DATE OF BIRTH (month, day, and year) August 19, 1843

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

84 7 --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster  
(State or country) Carroll Co. Md.

10 NAME OF FATHER Geo. Sheets.

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Rachel Crouse,

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Carroll Co. Md.14 Informant Geo. W. La Motte  
(Address) 4310 Walnut Ave.

1928 C. HANCOCK JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

17 I HEREBY CERTIFY, That I attended deceased from  
April 18, 1928, to April 19, 1928,  
that I last saw her alive on April 19, 1928,  
and that death occurred, on the date stated above, at 8 P. M.  
The CAUSE OF DEATH\* was as follows:Stroke Dilatation of  
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY General Arterio

(Secondary) Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) John S. Highland, M.D.

3/21, 1928 (Address) 1219 Poplar Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL. Providence Cemetery

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Geo. W. Little

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31915

## CERTIFICATE OF DEATH.

✓ E 31915

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *670 Kara Ann*2-FULL NAME *Sarah Williams*(a) RESIDENCE. NO. *670 Kara Ann*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs.

mos.

ds.

Now long in U. S., if of foreign birth? yrs.

mos.

ds.

ST.,

WARD.

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**col**widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1862*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*66**—**—*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

10 NAME OF FATHER

*George Williams*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Ann Brown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Md.*

14

Informant

(Address)

*Bessie Hayes**670 Kara Ann St.*

15

File

*21 1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 19* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 27*, 19*28*, to *Mar 19*, 19*28*.that I last saw him alive on *Mar 18*, 19*28*.and that death occurred, on the date stated above, at *12.30 P.* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*(duration) yrs. mos. *1* ds.

CONTRIBUTORY (Secondary)

(duration) *5* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical exam.*(Signed) *Chas. J. Keller*, M. D.3/20, 19*28* (Address) *222 W. Monument St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt Auburn Cem**3/21-28*

20 UNDERTAKER

ADDRESS

*Samuel E. Carter**816*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 18-29 Ward)2-FULL NAME John L. Green(a) RESIDENCE NO. 44 S. Carrollton Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if at foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Ellen Green6 DATE OF BIRTH (month, day, and year)  
Jan. 10, 18697 AGE Years 59 Months 2 Days 10 IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Laborer(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Lunch Room(c) Name of employer Wm. Green

## 9 BIRTHPLACE (city or town)

(State or country) Conn.10 NAME OF FATHER John Green11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Conn.12 MAIDEN NAME OF MOTHER Ellen Lawler13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Ireland14 Informant Mr. John L. Green(Address) 15 Selma Ave.

REGISTERED NO. \_\_\_\_\_

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 --28. 19217 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-  
topsy or inquiry.)inquiry and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) hrs. 16. yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) hrs. 1 yrs. mos. ds.  
(Signed) Regina J. Ellis M. D.  
(Coroner)3/22 1928 (Address) 2739 Eastern Ave.,\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificate.

PARENTS

MAR 21 1928

G. H. JONES, JR.

P. H.

New Cathedral Cemetery  
John F. Bourne & Son  
2018 Hallway



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31918

## CERTIFICATE OF DEATH.

E 31918

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 1-2 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 106 N. Stoner St., \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susanna6 DATE OF BIRTH (month, day, and year) June 16 18707 AGE Years \_\_\_\_\_ Months 9 Days 3 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 57

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter(b) General nature of industry, business, or establishment in which employed (or employer) Contractor(c) Name of employer Can Company9 BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) Maryland10 NAME OF FATHER James H. Kellam11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) Virginia12 MAIDEN NAME OF MOTHER Maria13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) Maryland14 Informant Robert Kellam (Address) 601 N. Simwood ave15 Registrar C. H. HARRISON

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said Inquest and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chor Myocarditis

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTAGIOUS (Secondary) Cardiac

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) M. D.(Address) 1436 73rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence: \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Cemetery, Calverton Date of Burial 3/22 192820 UNDERTAKER Wm Cook ADDRESS 502 E north

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31919

## CERTIFICATE OF DEATH.

E 31919

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1917 Herbert St. 15-21 Ward)2-FULL NAME John S. Patton(a) RESIDENCE NO. 1917 Herbert St. 15-21 Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)male white married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Carrie Patton

6 DATE OF BIRTH (month, day, and year)

March 257 AGE 61 YearsMonths 11Days 25IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workstone mason(b) General nature of industry,  
business, or establishment in  
which employed (or employer)Self

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md10 NAME OF FATHER Robert Patton

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.12 MAIDEN NAME OF MOTHER Isabella Taylor

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore Md.

## PARENTS

14

Informant  
(Address)Carrie Patton  
1917 Herbert St.

1928

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 192817 I HEREBY CERTIFY that I took charge of the  
remains described above, held inquest, autopsy or inquiry.)I am and from the evidence obtained by said inquest, au-  
topsy or inquiry, find that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(Signed) Wm Cook M. D.(Address) 143 W. E. Way\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVALLondon Park Cem Date of Burial 3/22 1928

20 UNDERTAKER

Wm Cook

ADDRESS

502 E. North

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31920

## CERTIFICATE OF DEATH.

E 31920

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital 2334 Ward)2-FULL NAME Carlyn Linton.(a) RESIDENCE NO. 1844 Light St.

(Usual place of abode)

St.        Ward       Length of residence in city or town where death occurred 4 yrs. 6 mos. 9 ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Single6a If married, widowed, or divorced HUSBAND of (or) WIFE of       6 DATE OF BIRTH (month, day, and year) September 10, 19287 AGE Years 4 Months 6 Days 9 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.(b) General nature of industry, business, or establishment in which employed (or employer)       (c) Name of employer       

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Wilbert Linton.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

## 12 MAIDEN NAME OF MOTHER

Anna Walters.

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.14 Informant Wilbert Linton. (father)(Address) 1844 Light St.

21 1928

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Turned about the face and body.  
Clothing ignited from a stove.  
Occidental Death.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)        M. D. (Coroner)3/21 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. ....mos. ....ds. In the State .....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death

1844 Light St. March 19, 1928

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

Loudon Park Cem. Mar 20 28  
Margaret J. Flynn 1422 Light St.

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31921

## CERTIFICATE OF DEATH

90 E 31921

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2245 E. Biddle St. Ward 8-12)

## 2-FULL NAME

(a) RESIDENCE NO. 2245 E. Biddle St. Ward 8

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Stindt6 DATE OF BIRTH (month, day, and year) Feb. 28, 18467 AGE Years 82 Months 0 Days 21 8 LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Wilhelm Wacker11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Lyna Heying13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Mrs. John Clark (Address) 2245 E. Biddle St.15 File 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1928 1917 I HEREBY CERTIFY, That I attended deceased from Nov. 1 - 1928 to Nov. 20, 1928that I last saw him alive on 3/20/28, 19and that death occurred, on the date stated above, at 3:21 m.The CAUSE OF DEATH was as follows: Chronic Myocarditis

CONTRIBUTORY (Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of 1Was there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) Arthur H. Jones M. D.19 (Address) 1340 E. Chese

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

is very important. See instructions on back of certificates.



Vuran Ellis

E 31922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31922

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 232 Fremont St. 41-29 Ward)

Registered No. ....

## 2-FULL NAME.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. ....

(Usual place of abode)

St. .... Ward. ....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. .... mos. .... ds.

How long in U. S. if of foreign birth? yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced (Write the word.)

Male

Colored

Single

5a-If married, widowed, or divorced HUSBAND or (or) WIFE of

6-DATE OF BIRTH (month, day and year)

1902

7-AGE,

26 yrs. .... mos. .... ds.

If LESS than 1 day,

.... hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Day

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country),

West India

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER,

Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

Unknown

14-

(Informant)

Wilfred Beckford

(Address)

232 3 Fremont Ave.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 19-28

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1928 to March 19, 1928

that I last saw him alive on March 14, 1928

and that death occurred, on the date stated above, at 645 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Pneumonia  
Phthisis

(Duration) .... yrs. .... mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Cook, M. D.

19 (Address) 561 W. Humboldt

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,

DATE OF BURIAL,

Not Auburn

Mar 23, 28

20-UNDERTAKER,

ADDRESS

Registrar

John H. Toadum

MAR 22 1928

N. JONES, R.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31923

## CERTIFICATE OF DEATH

REGISTERED NO.

E 31923

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *810 W. Ostend 71-79* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Frank Sims*(a) RESIDENCE NO. *810 W. Ostend* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 Color or Race

*Col*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

*Willie May Sims*

## 6 DATE OF BIRTH (month, day, and year)

*unknown 1880*

## 7 AGE

*47*

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

*Labrice etc*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

*Cottonton Alabama*

## 10 NAME OF FATHER

*Wm Sims*

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Alabama*

## 12 MAIDEN NAME OF MOTHER

*Unknown*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*

## 14

Informant (Address)

*Willie May Sims 810 W Ostend St*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*3/20 1928*I HEREBY CERTIFY, That I attended deceased from *Mar 12 1928* to *Mar 20 1928*that I last saw him alive on *Mar 20 1928*and that death occurred, on the date stated above, at *7 A m*

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *B. N. Hatcher* M. D.3/21 1928 (Address) *12 W Pa Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Cottonton altama March 22 1928*

## 20 UNDERTAKER

ADDRESS

*W. H. Brown & Son 108 W Montg Alabama B. and O. R. R. de Washington*

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31924

## CERTIFICATE OF DEATH.

57 E 31924

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 E. Pratt St. 2-4

WARD)

## 2-FULL NAME Anna C. Moloney

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO. 1914 E. Pratt St.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX F

## 4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) wid.

## 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

the late Michael Moloney

## 6 DATE OF BIRTH (month, day, and year) Feb 24, 1852

## 7 AGE

Years 76

Months 1

Days 25

If LESS than day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Wexford Ireland

## 10 NAME OF FATHER Patrick Capberry

## PARENTS

## 11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

## 12 MAIDEN NAME OF MOTHER Mary Irish

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

## 14

Informant (Address)

Mrs. Kath. O'Connell 1914 E. Pratt St.

## 15

Filed

AR 22 1928

H. J. Jones, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) March 19, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from June 1924, to March 19, 1928.

That I last saw her alive on March 18, 1928,

and that death occurred, on the date stated above, at 2:10 A. M.

The CAUSE OF DEATH\* was as follows:

Diabetes Mellitus  
Chr. Myocarditis.

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

residence

## Did an operation precede death?

No

Date of

## Was there an autopsy?

No

## What test confirmed diagnosis?

(Signed) Isaac Fenger, M. D.

3/19, 1928 (Address) 2902 E. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL CREMATION OR RE-

BIAL

## DATE OF BURIAL

## 20 UNDERTAKER

J. G. Moran

ADDRESS

E. Ballin

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31925  
PLACE OF DEATH101-001  
E 31925CITY OF BALTIMORE: (No. 316 Ellwood Ave 6-11 WARD)2-FULL NAME Catherine E. Dunn(a) RESIDENCE NO. 316 Ellwood Ave ST. 6-11 WARD(Usual place of abode)  
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) No5a If married, widowed, or divorced HUSBAND of (or) WIFE of No6 DATE OF BIRTH (month, day, and year) May 15 19267 AGE Years 1 Months 10 Days 5 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)10 NAME OF FATHER Peter P. Dunn11 BIRTHPLACE OF FATHER (city or town) Baltimore Md. (State or country)12 MAIDEN NAME OF MOTHER Myrtle E. Kilson13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or country)14 Informant Peter P. Dunn (Address) 316 N. Ellwood Ave15 Filed 22 1928 Registrar W. W. Conklin

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20, 192817 I HEREBY CERTIFY, That I attended deceased from 3/17, 1928, to 3/20, 1928.that I last saw her alive on 3/20, 1928.and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH\* was as follows:

Acute Lobar Pneumonia(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical(Signed) A. H. Hornstein M. D.3/21, 1928 (Address) 733 Asquith St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak Lawn Cemetery Mar 23 1928

UNDERTAKER

ADDRESS

Wm. W. Conklin 924 E. Eager St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31926

## CERTIFICATE OF DEATH.

166 E 31926

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-58 Ward 5)

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Weisz(a) RESIDENCE NO. 3427 Park Heights Ave St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. \_\_\_\_\_ ds. \_\_\_\_\_ How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofAlbert Weisz6 DATE OF BIRTH (month, day, and year) Sept 20/1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33	7	0	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse(b) General nature of industry, business, or establishment in which employed (or employer) City Hospital

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.10 NAME OF FATHER Isaac Berman11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Russia12 MAIDEN NAME OF MOTHER Rose Wagenheim13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Russia14 Informant Isaac Berman  
(Address) 26 S. Ann St15 Filed Mar 22 1928 Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Terminal Bronchopneumonia-Acute  
"nephritis"-hemorrhagic Gastritis(Autopsy at Sinai)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY Bichloride Mercury Pois-  
(Secondary) oning. SUICIDE(Signed) [Signature] M. D.  
(Coroner)(Address) 3/21/28 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Trendshtet 3/22/2820 UNDERTAKER Isaac Lewis ADDRESS 1439 E. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31927

## CERTIFICATE OF DEATH.

E 31927

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 957 N. Gay Street ST. 16-13 WARD)2-FULL NAME Mollie Ozeltman(a) RESIDENCE No. 957 N. Gay St

(Usual place of abode)

ST.,

WARD

Length of residence in city or town, where death occurred 22 yrs. mos.ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds. (If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE m5 Single, Married, Widowed, or Divorced, (write the word) widow5a If married, widowed, or divorced HUSBAND of or WIFE of Abraham Ozeltman6 DATE OF BIRTH (month, day, and year) March 21, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 66 — —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) Russia10 NAME OF FATHER Mandel Seff11 BIRTHPLACE OF FATHER (city or town, State or country) Russia12 MAIDEN NAME OF MOTHER Lochael13 BIRTHPLACE OF MOTHER (city or town, State or country) Russia

14

Informant (Address) Samuel Seire  
957 N. Gay St

15

Filed

MAR 22 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 20<sup>th</sup>, 1928 to March 21, 1928.that I last saw him alive on March 21, 1928.and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage  
(2nd attack)(duration) yrs. mos. ds. 8 yrs.CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) yrs. mos. ds. 8 yrs.18 Where was disease contracted if not at place of death? not knownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) Eugene J. Leppard, M. D., 19 (Address) 200 W. Lafayette Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Jack Lewis  
1439 E. Baltimore Ave.

E 31928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 33 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 2/7/1928, to 3/20/1928,

that I last saw him alive on 3/20/1928

and that death occurred, on the date stated above, at 12:10 P. M.

The CAUSE OF DEATH\* was as follows:

Subacute bacterial endocarditis  
Streptococcus viridans septicemia  
Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/21/1928

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

211658  
E 31929

51 E 31929

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 20-69 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Martin Rosenberg

## (a) RESIDENCE NO.

2105 Jefferson

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

June - 1916

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

School

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Morris Rosenberg

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Edith

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

## 14

Informant (Address)

Rebecca Jones, Johns Hopkins Hospital

## 15

Filed

MAR 22 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 21 1928

## 17

I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to March 21, 1928,

that I last saw him alive on March 21, 1928,

and that death occurred, on the date stated above, at 2:45 a. m.

The CAUSE OF DEATH\* was as follows:

Rheumatic myocarditis  
myocardial failure

(duration) 4 yrs. 10 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed)

J. J. Bennett M. D.  
Mar 21, 1928 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Baltimore Hebrew Cem

3/22/28

## UNDERTAKER

Jacob Lewis 1409 E. Baltimore

## ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31930

E 31930

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

CITY OF BALTIMORE: (No. *Woman's Hospital* ST *3-5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Sarah Rachael Berlin*(a) RESIDENCE NO. *1321 E. Baltimore St.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds. How long in U. S., if of foreign birth? *15* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Irish* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Isaac Berlin*6 DATE OF BIRTH (month, day, and year) *unknown*7 AGE Years *66 yrs.* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Russia* (State or country)10 NAME OF FATHER *Harry Goodman*11 BIRTHPLACE OF FATHER (city or town) *Russia* (State or country)12 MAIDEN NAME OF MOTHER *Wing* ?13 BIRTHPLACE OF MOTHER (city or town) *Russia* (State or country)14 Informant *J. Lewis* (Address) *1439 East Baltimore St.*15 Filed *1928* Registrar *J. Lewis*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 21* 19*28*17 I HEREBY CERTIFY, That I attended deceased from *March 17th*, 19*28*, to *March 21*, 19*28*, that I last saw him alive on *March 21*, 19*28*, and that death occurred, on the date stated above, at *1:45 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute appendicitis (ruptured)*  
*Generalized peritonitis*  
*Operation - mar. 17th Appendectomy*  
(duration) yrs. mos. *5* ds.CONTRIBUTORY *Malaria* (Secondary)(duration) yrs. mos. *1* ds.18 Where was disease contracted *Balls + Eden St.* if not at place of death?Did an operation precede death? *Yes* Date of *Mar 17, 1928*Was there an autopsy? *No*What test confirmed diagnosis? *Operation*(Signed) *H. H. H. H.* M. D.19 (Address) *Woman's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Wheeler-Kessem Rm*DATE OF BURIAL *Mar 28* 19*28*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 East Baltimore St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31931

## CERTIFICATE OF DEATH.

✓ 100-001  
E 31931

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 E. Bayes ST., 7-13 WARD)2-FULL NAME Louisa Richardson(a) RESIDENCE No. 1518 E. Bayes ST., 7-13 WARD(Usual place of abode)  
Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE C. 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Dec 7, 19097 AGE Years 18 Months 3 Days 13 If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) N. C. (State or country) \_\_\_\_\_10 NAME OF FATHER Wm. Richardson11 BIRTHPLACE OF FATHER (city or town) N. C. (State or country) \_\_\_\_\_12 MAIDEN NAME OF MOTHER Bettie Flannery13 BIRTHPLACE OF MOTHER (city or town) N. C. (State or country) \_\_\_\_\_14 Informant Ella Richardson (Address) 1518 E. Bayes St.15 AR 22 1928 Registrar [Signature]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20-191817 I HEREBY CERTIFY, That I attended deceased from 3-18-1918, to 3-20-1918, that I last saw him alive on 3-19-1918, and that death occurred, on the date stated above, at 2 A m.The CAUSE OF DEATH\* was as follows:  
Bronch. Pneumonia(duration) \_\_\_\_\_ yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? \_\_\_\_\_

(Signed) W. H. Hargis, M. D.3-21-1918 (Address) 611-17. Canal

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Walesboro N. C.Mar. 20, 1918

UNDERTAKER

ADDRESS

Wm. R. G. Elliot1725 Ashland Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31932  
1-PLACE OF DEATH100-001  
E 31932  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 121 N. Chapel ST. 6-9 WARD)2-FULL NAME William Henry(a) RESIDENCE NO. 121 N. Chapel ST. Life WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 17, 19287 AGE Years Months Days 2 2 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER Gayfield Henry11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)12 MAIDEN NAME OF MOTHER Lettie Henry13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)14 Informant Lettie Henry (Address) 121 N. Chapel St.15 Filed 2-27-1928 Registrar Wm. P. A. Elliott

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20-192817 I HEREBY CERTIFY, That I attended deceased from 3-15-1928 to 3-20-1928that I last saw him alive on 3-19-1928 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. P. A. Elliott, M. D.2-21, 1928 (Address) 64-11 E. Calver

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 31933

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

66 E 31933

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 E North ave ST. 8-18 WARD)2-FULL NAME William L. Larson(a) RESIDENCE NO. 1208 E North ave  
(Usual place of abode)Length of residence in city or town where death occurred 70 yrs. mos. ds. ST. WARD  
(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Leanova V. Larson or WIFE of6 DATE OF BIRTH (month, day, and year) July 21<sup>st</sup> 18547 AGE Years 74 Months 1 Days 1 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harrisonburg (State or country) Va10 NAME OF FATHER John F. Larson11 BIRTHPLACE OF FATHER (city or town) Int Royal (State or country) Vermont12 MAIDEN NAME OF MOTHER Amos C. Long13 BIRTHPLACE OF MOTHER (city or town) Harrisonburg (State or country) Vermont14 Informant Mrs Leanova V. Larson (Address) 1208 E North ave15 Filed George Schilling Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21 19 2817 I HEREBY CERTIFY, That I attended deceased from March 17, 19 28, to March 21, 19 28, that I last saw him alive on March 20, 19 28, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic AlcoholismEdema of brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Shad M. D.7/21/1928 (Address) 1106 E North ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St. Olivet Cemetery  
George SchillingMar 24<sup>th</sup> 1928  
1126 E. Monument St



E 31934

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Memorial Hospital

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Walter Warner

(a) RESIDENCE NO.

5019 Toga Ave.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

70 yrs. 9

mos. 20 ds.

How long in U. S. If of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 31934

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Laura Weston Warner?

6 DATE OF BIRTH (month, day, and year)

May 24, 1857

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or — min.

70

9

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Custodian of vault

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

George Warner

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Suzanne Foultz

13 BIRTHPLACE OF MOTHER (city or town)

Pa.

(State or country)

14

Informant (Address)

Laura Weston Warner  
5019 Toga Ave.

15

Filed

S. J. JONES, R. J.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 20, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 3, 1928, to March 20, 1928  
that I last saw him alive on March 20, 1928,

and that death occurred, on the date stated above, at 12:05 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of bladder

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

Yes Date of Feb. 28, 1928

Was there an autopsy?

No

What test confirmed diagnosis?

Biopsy

(Signed)

Maurice C. C. M. D.

, 19

(Address) Union Memorial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Olivet Cemetery

DATE OF BURIAL

Mar 20, 1928

20 UNDERTAKER

George Schilling &amp; Sons

ADDRESS

1126 Monument

100-001  
E

E 31935

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-19

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 19<sup>192</sup>/28

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an Inquiry  
(Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-  
**inquiry**.....and that said deceased came to **his** death  
 topsy or inquiry.)  
 on the day stated above.

The CAUSE OF DEATH\* was as follows:

## Bronchopneumonia (Primary)

(Autopsy)

(duration) ..... yrs. .... mos. .... ds.

**CONTRIBUTORY**  
(Secondary)

(Signed) John M. [Signature] M. D.  
(Coroner)

3/22/28<sup>19</sup> (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
--	----------------

20 UNDERTAKER

REMOVAL	Ashbury Ceme.	Nov 22 1928
20 UNDERTAKEN	Mrs J. G. Locks	ADDRESS 1302 1/2 Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31936

## CERTIFICATE OF DEATH.

90 E 31936

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Martin House of Wre* St. *10-14* Ward)

Registered No. ....

2-FULL NAME *Mary Estelle Mahoney*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *Asquith & Ashland Ave.* Ward. ....

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. .... mos. .... ds. How long in U. S. if of foreign birth? yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Female*

4-COLOR OR RACE,

*White*

5-Single, Married, Widowed, or Divorced (Write the word.)

*Single*

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) *March 14, 1871*

7-AGE,

*57* yrs. .... mos. .... ds.

If LESS than 1 day,

.... hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Teacher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town).

(State or Country),

*Marquette, Minn.*

10-NAME OF

FATHER,

*Michael Mahoney*

11-BIRTHPLACE

OF FATHER (city or town)

(State or Country),

*Ireland*

12-MAIDEN NAME

OF MOTHER,

*Mary Duke*

13-BIRTHPLACE

OF MOTHER (city or town)

(State or Country),

*Ireland*

14-

(Informant) *Sister Mary Elionide*(Address) *Asquith Street*

15-

FILE

22 1928

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## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31937

## CERTIFICATE OF DEATH.

E 31937

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3032 Walbrook Ave. ST. 15-67 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 3032 Walbrook Ave. ST. 15-67 WARD

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 26 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of or WIFE of Charles E. Day6 DATE OF BIRTH (month, day, and year) May 22 18597 AGE Years 68 Months 10 Days 29 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Thomas Matthews11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Sarah A. White13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant J. J. Wilkinson (Address) 3032 Walbrook Ave.15 Filed AR 22 1928 Registrar John S. Jones, Jr.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21<sup>st</sup> 192817 I HEREBY CERTIFY, That I attended deceased from Mar 2 -, 1928, to Mar 21<sup>st</sup>, 1928, that I last saw her alive on Mar. 21 -, 1928,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis with Enlarged Liver.(duration) 6 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac L. Dickson, M. D.(Address) 3055 N. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Boconoke City IndMar 22, 1928

20 UNDERTAKER

ADDRESS

Isaac Syfer1600 N. North Ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31938

## CERTIFICATE OF DEATH.

E 31938

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital 26-37* ST. *26-37* WARD)2-FULL NAME *Mrs. Katherine Adams*(a) RESIDENCE No. *4324 E. Lombard* ST. *26-37* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *37* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Joseph W. Adams*

6 DATE OF BIRTH (month, day, and year)

*Mar 24/51*

7 AGE

Years *76* Months *11* Days *21* If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Horsework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at Home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Pa.*

10 NAME OF FATHER

*Do not know*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

*Mrs. Lloyd 4312 Lombard St City*

15

Filed

*7/2/28*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-21* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from *2-13-28*, 19*28*, to *3-21*, 19*28*.that I last saw him alive on *3-21*, 19*28*.and that death occurred, on the date stated above, at *7:40 P M*

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*  
*Diabetes mellitus*CONTRIBUTORS (duration) yrs. mos. ds.  
*Diabetic gangrene of ft*  
*perine* (duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Francis L. Sadayhacoe M.D.*

, 19 (Address)

*St Agnes Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*McBarnum**3/24 1928*

20 UNDERTAKER

*Philip Herwig*

ADDRESS

*2016 Orleans*

TION is very important See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31939

## CERTIFICATE OF DEATH.

91-002  
E 31939  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Harford Ave ST. 9-18 WARD)2-FULL NAME Bessie M. Gleason(a) RESIDENCE NO. 1422 Harford Ave ST. 9-18 WARD(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Michael F. Gleason (or) WIFE of6 DATE OF BIRTH (month, day, and year) Oct 28/097 AGE Years 58 Months 4 Days 22 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)10 NAME OF FATHER Patrick Clarke11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Mary Clarke13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant Michael F. Gleason (Address) 1422 Harford Ave15 AR 22 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21 19 2817 I HEREBY CERTIFY That I attended deceased from Jan 27, 19 27 to March 21, 19 28 that I last saw him alive on March 20, 19 28and that death occurred, on the date stated above, at 2 30 A. M.

The CAUSE OF DEATH\* was as follows:

Arterio SclerosisCONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 14 yrs. 14 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Leary, M. D.(Address) 413 W Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Peters Cem.

DATE OF BURIAL

3/24 19 28

20 UNDERTAKER

Philip HennigADDRESS 2016  
Oileans H.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31940

## CERTIFICATE OF DEATH.

E 31940

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42 St. Helens Av. Hamilton

2-FULL NAME John H.L. Hildenbrand

(a) RESIDENCE NO. #42 St. Helens Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Lillian M. Hildenbrand (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 29/95

7 AGE Years 32 Months 6 Days 20 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fairfield Dairy Co.

9 BIRTHPLACE (city or town) (State or country)

Phila. Pa.

10 NAME OF FATHER Louis W. Hildenbrand

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Penna.

12 MAIDEN NAME OF MOTHER Catherine Loukes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14 Informant Lillian M. Hildenbrand (Address) 42 St. Helens Ave

15 Filed AR 22 1928 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 1928

17

I HEREBY CERTIFY, That I attended deceased from 3/17, 1928, to 3/20, 1928, that I last saw him on 3/20, 1928, and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Kyle W. Golley, M. D.

19 (Address) 5012 Harford Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park

DATE OF BURIAL

3/23/28

ADDRESS

20 UNDERTAKER

Philip Henry 2016 Orleans St.

Sarah Studnetsky  
HEALTH DEPARTMENT—CITY OF BALTIMORE

31941

31941

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital 15-58 Ward)2-FULL NAME Sarah Studnetsky(a) RESIDENCE NO. 3600 Park Heights Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofSamuel Studnetsky

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than  
76 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Housewife(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Isah

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Fagie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia14 Informant Mrs. Anne Forman (Daughter)(Address) 2907 Eeyworth Ave.15 Filed..... 19 2-27-28

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21-192817 I HEREBY CERTIFY That I took charge of the  
remains described above, held a Inquiry  
(Inquest, autopsy or inquiry.)Person and from the evidence obtained by said Inquest  
and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH was as follows:

St. Car Accident  
Multiple Fractures

## CONTRIBUTORY

St. Car Accident (duration) 4 yrs. mos. ds.St. Car Accident (duration) 1 yrs. mos. ds.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL Rosedale 3/27/28

20 UNDERTAKER

ADDRESS

Josh Lewis 1439 E. Baltimore



E 31942

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

\* 57 E 31942

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Astor Court Sts. 12-50*)

WARD)

## 2-FULL NAME

*Dore Bertrude Prince*

## (a) RESIDENCE NO.

*Hydes Md*

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. *6* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Widow*

## 5a If married, widowed, or divorced, HUSBAND or WIFE of

*Leslie H. Prince*

## 6 DATE OF BIRTH (month, day, and year)

*Sept. 13 1862*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*65**6**8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Ohio*

## 10 NAME OF FATHER

*Francis Wilson*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Pa*

## 12 MAIDEN NAME OF MOTHER

*Frances Rodney*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Md.*

## 14

Informant (Address)

*Mrs. James D. Arthur Hydes Md.*

## 15

Filed

19

*K. M. S. K. D. Registrar*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Mar. 21 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from *March 16, 1928*, to *March 21, 1928*.that I last saw her alive on *March 21, 1928*,and that death occurred, on the date stated above, at *2:45 a.m.*

The CAUSE OF DEATH\* was as follows:

*Acute Myocarditis*

(duration) yrs. mos. ds.

## CONTRIBUTOR (Secondary)

*Robert Meekley & Chronic Bronchitis*

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

*Exam & serum & blood*

(Signed)

*Dr. J. M. S. K. D.*

M. D.

19 (Address)

*705 Meade St. Bklyn*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

## DATE OF BURIAL

*Wood Ridge Cem.**Mar. 24 1928*

## 20 UNDERTAKER

## ADDRESS

*Wm. J. Pickner Sons.**North Ha*

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 31943

## CERTIFICATE OF DEATH.

90 E 31943

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3511 Copley Rd

ST. 15-62 WARD)

## 2-FULL NAME Mary A. Strahan

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3511 Copley Rd.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 33 yrs.

How long in U. S. If of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

5a If married, widowed, or divorced HUSBAND or (or) WIFE of Theodore Strahan

6 DATE OF BIRTH (month, day, and year) Jan. 16, 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

78

2

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Co

Md.

10 NAME OF FATHER Josiah W. Earl

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER Carback

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Rev. Benj. W. Meeks 309 Woodlawn Rd.

15

Filed

19

J. H. JONES, R. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 19 1928

17

I HEREBY CERTIFY, That I attended deceased from December 1927, to March 19, 1928, that I last saw her alive on March 19, 1928, and that death occurred, on the date stated above, at 9.50 P. M.

The CAUSE OF DEATH\* was as follows:

acute pulmonary edema from failing heart

(duration) — yrs. — mos. one ds.

CONTRIBUTORY (Secondary)

Chronic myocarditis &amp; endocarditis

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shamus, M. D.

3/2 1928 (Address) 3300 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Rosaline Cemetery

Mar 1928

20 UNDERTAKER

ADDRESS

Wm. J. McKenrick Sons

North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31944

## CERTIFICATE OF DEATH.

E 31944

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31945

## CERTIFICATE OF DEATH.

X 38 E 31945

1-PLACE OF DEATH *Church Home & Infirmary*  
CITY OF BALTIMORE: (No. *Broadway + Fairmount*) WARDREGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2-FULL NAME *Robert E. Steele*(a) RESIDENCE NO. *334 Ashboro St Greensboro N.C.*  
(Usual place of abode)Length of residence in city or town where death occurred yrs. mos. *22* How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Miranda Steele*6 DATE OF BIRTH (month, day, and year) *Nov 21-1869*7 AGE Years *58* Months *4* Days *0* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Wholesale Merchant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Self.*9 BIRTHPLACE (city or town) *Wilmington*  
(State or country) *East Bank, N.C.*10 NAME OF FATHER *L. S. Steele*11 BIRTHPLACE OF FATHER (city or town) *NC.*  
(State or country)12 MAIDEN NAME OF MOTHER *James Steele*13 BIRTHPLACE OF MOTHER (city or town) *N.C.*  
(State or country)14 Informant *R. D. McLaughan*  
(Address) *Winston-Salem, N.C.*15 Filed *7-2-1928* *W. J. Jones, Jr.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 21-1928*17 I HEREBY CERTIFY, That I attended deceased from *Feb 29*, 1928, to *Mar 21*, 1928.that I last saw him alive on *March 21*, 1928,and that death occurred, on the date stated above, at *5:45 P.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebro Spinal Syphilis.*(duration) yrs. *4* mos. ds.CONTRIBUTORY *Broncho Pneumonia*  
(Secondary)(duration) yrs. mos. *3* ds.18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes.*What test confirmed diagnosis? *Wasserman Reaction*  
(Signed) *George B. Price* M. D.19 (Address) *Church Home & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Wilmington, N.C.*

DATE OF BURIAL

20 UNDERTAKER

*Wm. Heckner Sons*

ADDRESS

*North St.*

TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31946

## CERTIFICATE OF DEATH.

31 E 31946

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 1/2 Harlem Ave. 16-23 WARD)

## 2-FULL NAME

Margaret Wilson

## (a) RESIDENCE NO.

1309 1/2 Harlem Ave ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds.

How long in U. S., if of foreign birth? life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

7

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Wife

## 6 DATE OF BIRTH (month, day, and year)

Feb 29, 1904

## 7 AGE

24

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession, or  
particular occupation

House Work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Fairmont W Va

## 10 NAME OF FATHER

Samuel Wilson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Anna Wilson

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Va

## 14

Informant

Anna Wilson

(Address)

1309 1/2 Harlem Ave

Filed

19

J. JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20-1928

17

I HEREBY CERTIFY, That I attended deceased from

3-19-1928 to 3-19-1928

that I last saw her alive on 3-19-1928

and that death occurred, on the date stated above, at 3.00 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. H. Langenbach, M. D.

-20, 1928 (Address) 2215 N. Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Mount Lion 3-22-1928

## 20 UNDERTAKER

## ADDRESS

Joseph A. Swick at Mount

TION is very important See instructions on back of certificates.



## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 31948

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1019 S. Ellwood Ave

## 2-FULL NAME

(a) RESIDENCE No. 1019 S. Ellwood Ave

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO. 31948

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAR 22 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1928

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to Mar 20, 1928, that I last saw him alive on Mar 20, 1928,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Florence B. Vetter, M. D.

3/21, 1928 (Address) 315 S. Highland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 3000

E 31949 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31949

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Vincent's Infant Asylum* WARD)2-FULL NAME *Chester Milburn*(a) RESIDENCE NO. *St Vincent's Infant Asylum* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan. 4, 1924*7 AGE Years Months Days *4* *2* *17* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Washington D.C.* (State or country)10 NAME OF FATHER *Samuel Milburn*11 BIRTHPLACE OF FATHER (city or town) *Unknown* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)

14

Informant *St Vincent's Infant Asylum* (Address) *Lafayette Ave & Division St*

15

MAR 22 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 21 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 15, 1928* to *March 21, 1928*, that I last saw him alive on *March 21, 1928*, and that death occurred, on the date stated above, at *8 P m.* The CAUSE OF DEATH\* was as follows:*Whooping Cough -*CONTRIBUTORY (Secondary) *Bronchitis pneumonia* (duration) yrs. mos. *20* ds.(duration) yrs. mos. *5* ds.18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Chas. R. Goodborough*, M. D., 19 (Address) *2923 St Paul St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Holy Redeemer*  
*Martin Fisher & Sons**March 22 1928*  
*1827 N. North Ave*

TIO is very important. See instructions on back of certificates.



E 31950 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 Bank Street

ST. 2-4 WARD

2-FULL NAME HARRY G. REVIER

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1737 Bank Street

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 72 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 72 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

 5a If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of Marthe M. Revier

6 DATE OF BIRTH (month, day, and year) August 8, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7	12	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barrel Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Holland

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Holland

12 MAIDEN NAME OF MOTHER Inje Jacobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Holland

14

 Informant Mrs. Marthe M. Revier (Wife)  
 (Address) 1737 Bank Street

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1928

17

 I HEREBY CERTIFY, That I attended deceased from  
 March 12, 1928, to March 20, 1928,  
 that I last saw him alive on March 20, 1928  
 and that death occurred, on the date stated above, at 3 p. m.  
 The CAUSE OF DEATH\* was as follows:

Myocarditis (chronic)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

 (Signed) Eugene L. Passajho, M. D.  
 3.21.1928 (Address) 514 Drury Lane

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Mar. 23 1928

20 UNDERTAKER

Henry Sander &amp; Sons Inc

 ADDRESS  
 Baltimore St.  
 & BROADWAY

TION is very important See instructions on back of certificates.

MAR 22 1928

 HARRY G. REVIER  
 Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 31951

101-00

E 31951

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 1-3 Ward)

2-FULL NAME LESTER J. H. CONNER Jr.

(a) RESIDENCE NO. 704 S. Port Street

(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds.

St. 1-3 Ward

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)  
Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of  
---

6 DATE OF BIRTH (month, day, and year)

May 8, 1926

7 AGE

Years

1

Months

10

Days

12

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

10 NAME OF FATHER Lester J.H. Conner Sr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Mary Bangert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Mrs. Mary Conner (Mother)

(Address)

704 S. Port Street

15 MAR 22 1928 DAVIDSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) August J. Gellert M. D. (Coroner)

3/21, 1928 (Address) 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Oak Lawn Cemetery

Mar 23, 1928

UNDERTAKER

Henry Sander & Sons Inc

ADDRESS

1710 Fleet St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

E 31952 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31952

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital

## 2-FULL NAME

Harry Sipple

## (a) RESIDENCE NO.

3023 Rosalind Ave. Balt. Md.

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Alice Sipple

## 6 DATE OF BIRTH (month, day, and year)

May 13, 1890

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

37 yrs.

10

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Reinle Salmon Co.

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md.

## 10 NAME OF FATHER Charles Sipple

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER Margaret Rhodes

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

Mrs. Alice Sipple (Wife)  
3023 Rosalind Ave.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 21 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

1-29, 1928, to Mar 21, 1928.

that I last saw him alive on Mar 21, 1928

and that death occurred, on the date stated above, at 2:10 a. m.

The CAUSE OF DEATH\* was as follows:

Pericarditis (fibrous)  
(Non-tuberculous)

(duration) yrs. 7 mos. ds.

## CONTRIBUTORY (Secondary)

Myocarditis (duration) yrs. 15 mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2/21/28

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signature) Augustine P. Von Schue D.

Address 1111 E. Agnes. No. 10

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

## DATE OF BURIAL

Mar. 24, 1928

## 20 UNDERTAKER

Henry Sander &amp; Sons Inc

ADDRESS  
Baltimore &  
BROADWAY.

TION is very important See instructions on back of certificates.

MAR 22 1928

JONES, H. H.

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31953

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

154 2 North Broadway

CITY OF BALTIMORE: (No. 154 2 North Broadway ST.: 8 WARD)

2-FULL NAME

Thomas Joseph Kelly

(a) RESIDENCE. No. 154 2 North Broadway

(Usual place of abode)

ST. 8 WARD.

Length of residence in city or town where death occurred

80 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

80 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

Josephine Kelly

6 DATE OF BIRTH (month, day, and year)

Dec. 21, 1839

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

88

3

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physician and druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

Proctor &amp; Co. 154

(c) Name of employer

John Kelly

9 BIRTHPLACE (city or town)

Ireland

(State or country)

10 NAME OF FATHER

John Kelly

11 BIRTHPLACE OF FATHER (city or town)

Ireland

(State or country)

12 MAIDEN NAME OF MOTHER

Kathleen Barlow

13 BIRTHPLACE OF MOTHER (city or town)

Ireland

(State or country)

14

Informant

(Address)

John J. Kelly (son)  
154 2 N. Broadway

15

Filed

19

RAMPON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 21, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1, 1928, to Mar. 21, 1928.

that I last saw him alive on Mar. 21, 1928.

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY

(Secondary)

Enterovascular

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

No special tests

(Signed)

C. J. Macdonald, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery

3/23 1928

20 UNDERTAKER

ADDRESS

George J. Ruth

1735 Maryland

TION is very important. See instructions on back of certificates.

22 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31954

E 31954  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2524 Eagle Place St. 7-17 Ward)2-FULL NAME Lillian M. Bernik(a) RESIDENCE NO. 2524 Eagle Place St. 7-17 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) Sept. 8/19257 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
2 6 11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —

## 9 BIRTHPLACE (city or town)

(State or country) Baltimore10 NAME OF FATHER George P. Bernik

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore12 MAIDEN NAME OF MOTHER Mildred

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

## 14

Informant (Address) George P. Bernik  
2524 Eagle Place

## 15 Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19 19 2817  
HEREBY CERTIFY, That I attended deceased from Feb. 28, 1928, to March 10, 1928, that I last saw her alive on March 19, 1928, and that death occurred, on the date stated above, at 1:12 A.M.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia  
(primary)  
(duration) ..... yrs. .... mos. 17 ds.  
CONTRIBUTORY pneumococcus meningitis  
(Secondary) + septicemia  
(duration) ..... yrs. .... mos. 3 ds.

## 18 Where was disease contracted

If not at place of death, residenceDid an operation precede death? No Date of.....Was there an autopsy? No

What test confirmed diagnosis?

Signed) Grace Feiglin, M. D.  
3/20 1928 (Address) 2005 E. Rutger

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery Date of Burial March 29, 1928

## 20 UNDERTAKER

George J. Ruth 1735 Harford Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 31955

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31955

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 W 28th St)

ST. 12-51 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 500 W 28th St

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY That I attended deceased from

Mar 19, 1928, to Mar 21, 1928

that I last saw him alive on

Mar 21, 1928

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH\* was as follows:

Acute Cordial Dehydration

Sudden

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Signature: E. P. Richardson M.D.

(Address)

112 W. 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

27 1928

J. H. HARRISON, Registrar

THIS IS VERY IMPORTANT - See instructions on back of certificates.

31956

## HEALTH DEPARTMENT--CITY OF BALTIMORE

31956

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HO. ST. WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

2-FULL NAME Dimiter Cassaway(a) RESIDENCE No. 910 W. Ashmont ST., WARD

(Usual place of abode)  
 Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 Single, Married, Widowed,  
 or Divorced, (write the word) Married

5a If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2

7 AGE Years Months Days If LESS than  
23 1 day. hrs.  
 or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Dimiter Cassaway11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Maria13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14

Informant  
 (Address)

15

22 1928

G. HAMMOND JOHNS, M. D.  
P. 2270 R.M.  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/28

17

I HEREBY CERTIFY, That I attended deceased from  
Sept. 22, 1927, to Mar. 18, 1928  
 that I last saw him alive on Mar. 18, 1928

and that death occurred, on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. mos. 6 ds.CONTRIBUTORY Sales cerebralis

(Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Salt(Signed) C. William Boyd, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAR 22 1928

20 UNDERTAKER Flowers  
Commissioner Health

ADDRESS

E 31957

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31957

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

## 2-FULL NAME

(a) RESIDENCE NO. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

C. KAMPEON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar. 12, 1928, to Mar. 13, 1928,  
that I last saw her alive on Mar. 13, 1928,  
and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia, bronchio

(duration) yrs. mos. 5 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. E. Blotson, M. D.

, 19 (Address) Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

PARENTS is very important. See instructions on back of certificates.



E 31958

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31958

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1956 W. Kullback ST. 20-27 WARD)

## 2-FULL NAME Salustian Porfory

(a) RESIDENCE NO. 1956 W. Kullback  
(Usual place of abode)

Length of residence in city or town where death occurred 25+ yrs.

ST. WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Antonio Porfory

6 DATE OF BIRTH (month, day, and year) 1889 March 18

7 AGE 90 Years Months Days

89 yrs.

4

2

If LESS than  
1 day,  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Italy

10 NAME OF FATHER John Battaglin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER Mary Camaggio

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Joseph Porfory (son) 1956 W. Kullback ST.

15

FILED

C. J. JAMES, M. D.

22 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21-1928

I HEREBY CERTIFY, That I attended deceased from Feb. 5-1928, to Mar. 21-1928.

That I last saw her alive on March 20, 1928.

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Valvular disease, Cardiac,  
Mitral regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Asthma, sig. fever

(duration) yrs. mos. 45 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gram stain

(Signed) H. Paul

M. D.

3/11, 1928 (Address) 1301 1/2 Paul

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Ann Cathedral (city)

3/23 1928

20 UNDERTAKER

ADDRESS

William Cook

502 E. North Ave.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

E 31959

## CERTIFICATE OF DEATH

7 ✓ E 31959

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No

2-FULL NAME

(Residence in Baltimore: No.

2043 E. Eager St

Alberta<sup>M</sup> Amick

2043 E. Eager St

ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male  
female

4-COLOR OR RACE

white

5-SINGLE,

MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6-DATE OF BIRTH

July

17, 1928

7-AGE

1 yrs. 8 mos. 5 ds.

If LESS than  
1 day, hrs.  
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE

(State or country)

Baltimore Md

10-NAME OF FATHER

Charles W Amick

PARENTS

11-BIRTHPLACE OF FATHER  
(State or country)

Baltimore Md

12-MAIDEN NAME OF MOTHER

Blanche Davis

13-BIRTHPLACE OF MOTHER  
(State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles W Amick

(Address) 2043 E. Eager St

15.

Filed

G. RAMFON JONES, M. D.

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

March

22, 1928

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1928, to March 22, 1928.

that I saw h alive on March 22/28, 1928, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH\* was as follows:

Measles

(Duration)

yrs.

mos.

4 ds

Contributory (SECONDARY)

Bronchio Pneumonia

(Duration)

yrs.

mos.

2 ds

(Signed)

Frank J. Ayd

M. D.

March 22, 1928

(Address)

2005 E. Monument St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs.

mos.

In the

ds. State yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore

DATE OF BURIAL

3/23, 1928

20-UNDEERTAKER

Wm. Cook

ADDRESS

512 E. North Ave

E 31960

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31960

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (JOHNS HOPKINS HOSPITAL)

ST., 7-9 WARD)

2-FULL NAME Lauren Langmade

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. North Baltimore, Ohio

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (Write the word)

Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Cone

6 DATE OF BIRTH (month, day, and year) 4-22-53

7 AGE

75

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

William Langmade

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Canada

12 MAIDEN NAME OF MOTHER

Annie Record

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

New York

14

Informant (Address)

Cone

15

Filed

19

G. ALMON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1928, to March 22, 1928.

that I last saw him alive on March 22, 1928.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Benign Prostatic Hypertrophy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 44 Date of Feb 15-28

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed)

Robert W. Winkley, M. D.

19

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

North Baltimore, Ohio.

DATE OF BURIAL

Mch 22 19 28

20 UNDERTAKER

ADDRESS

Hughes &amp; Jones, Inc. 424 N. Broadway

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE **E 31961****31961**

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 100 W. BarreSt. 22-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ward(a) RESIDENCE NO. 100 W. BarreSt. 22-30 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winifred Ward6 DATE OF BIRTH (month, day, and year) Feb. 25, 18467 AGE Years 82 Months 0 Days 21 IF LESS than 1 day... hrs. or... min..8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Retired Soldier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md. (State or country)10 NAME OF FATHER Patrick Ward11 BIRTHPLACE OF FATHER (City or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Mary Kump13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant John P. Ward (son) (Address) 42 Brooklyn Ave15 Filed 22 1928 G. Hampton Jones, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 192817 I HEREBY CERTIFY, That I attended deceased from March 10, 1928 to March 21, 1928 that I last saw him alive on March 21, 1928 and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH\* was as follows:

myocarditis  
chronic nephritis  
auricular fibrillationCONTRIBUTORY Dehydration of Heart (duration) yrs. mos. ds. (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis Physical Exam.(Signed) Edward Morris, M. D.3.21.1928 (Address) 107 East wecker

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

National CemeteryMar. 23, 1928

UNDERTAKER

Margaret J. Flynn1422 Highland

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-MAT-1500 Bks.

E 31962

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 Varney ST., 24 WARD)

### 2-FULL NAME

(a) RESIDENCE NO. 644 Varney ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

1 SEX Male

2 COLOR OR RACE White

3 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosina Hitter

6 DATE OF BIRTH (month, day, and year) 8-27-1847

7 AGE 85

Years

Months

Days

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14

Informant (Address) Mrs. Mary H. Hitter 644 Varney St.

15

22 1928

19

REGISTRAR

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22-1928

17

I HEREBY CERTIFY, That I attended deceased from Mar. 22, 1928, to Mar. 22, 1928.

that I last saw him alive on Mar. 22, 1928.

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH was as follows:

Apoplexy

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Hitter M. D.

3/22/28 (Address) 1212 N. ...

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 31963

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31963

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Baltimore City Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.,

WARD)

2-FULL NAME

Thomas Ward (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Unknown

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

59

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

J. B. Jones

15

Filed

22-1928

J. B. Jones, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/18

1928

17

I HEREBY CERTIFY, That I attended deceased from

3/8

1928, to

3/18

1928,

that I last saw him alive on

3/18

1928,

and that death occurred, on the date stated above, at

4:30 A.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Penis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

Yes

Date of

3/12/28

Was there an autopsy?

No

What test confirmed diagnosis?

Chemical

(Signed)

R. M. Jones

M. D.

, 19

(Address)

Baltimore City Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

1318 Lighter

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31964

## CERTIFICATE OF DEATH.

66 ✓  
REGISTERED NO.

E 31964

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 57 So. Monroe St. 19-28) Ward 6

## 2-FULL NAME

Bessie Campbell

## (a) RESIDENCE NO.

57 So. Monroe St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

white

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Harry A. Campbell

## 6 DATE OF BIRTH (month, day, and year)

May 19 1883

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

44 10 1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Va

(State or country)

## 10 NAME OF FATHER

Robt Jones

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

Sallie Ransick

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)Harry A. Campbell  
57 So. Monroe St.

## 15 Filed

16

J. J. JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, and made a report thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Nephritis  
Found dead in bed  
(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Dach (Address) 24 1928 (Address) Curtis Bay

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Not Olcut Cemetery  
Under taker  
Address

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

AN 23 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31965

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. (A.B.) WARD)2-FULL NAME Mary E. Phelps(a) RESIDENCE No. 1829 N. Durham st.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ST. WARD

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed, or Divorced, (write the word)  
Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofJohn Phelps6 DATE OF BIRTH (month, day, and year) 1906

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland10 NAME OF FATHER Geo. Hoffman11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Mary E. Born13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland14 Informant Hospital Records  
(Address)

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 17, 19 28, to March 21, 1928,  
that I last saw her alive on March 21, 1928,  
and that death occurred, on the date stated above, at 2.45 a. m.  
The CAUSE OF DEATH\* was as follows:Pulmonary tuberculosis(duration) Unknown yrs. mos. ds.CONTRIBUTORY Tuberculous laryngitis  
(Secondary)(duration) Unknown yrs. mos. ds.18 Where was disease contracted  
if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis Clinical & Lab.(Signed) [Signature], M. D.  
(Address) Baltimore City Hospitals.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

[Signature] Mar 24 1928

UNDERTAKER ADDRESS

Registrar

See instructions on back of certificates.

AR 23 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31966

1-PLACE OF DEATH

City of BALTIMORE: (No. 4503 Pemburst Ave 28 63 Wd)2-FULL NAME Wm B Aldridge(a) RESIDENCE NO. 4503 Pemburst

(Usual place of abode)

Length of residence in city or town where death occurred LIFE yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie = E = Taylor6 DATE OF BIRTH (month, day, and year) Feb 4, 18567 AGE Years 72 Months 1 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown12 MAIDEN NAME OF MOTHER Rachel Meredith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14

Informant R = T = Aldridge(Address) 4503 = Pemburst ave

15

Filed 23 1926

19

Name Wm B AldridgeAge 72Sex MRace WMarried YesOccupation RetiredSignature Wm B Aldridge

Registrar

REGISTERED NO. 91-002

E 31966

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 192817 I HEREBY CERTIFY That I took charge of the remains described above, held a Inquest (Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said Inquest and that said deceased came to this death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Aortic SclerosisCONTRIBUTORY (Secondary) ArteriosclerosisSigned Geo Chubb Rade M. D. (Coroner)19 (Address) 143801 Emory

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Mar 23 '820 UNDERTAKER John O Mitchell & Sons ADDRESS 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31967

## CERTIFICATE OF DEATH.

E 31967

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church House & Infirmary 15-61* ST. *15-61* WARD)

## 2-FULL NAME

*Bradford Rich*

## (a) RESIDENCE NO.

*6205 Clifton Ave*

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *65* yrs. *2* mos. *15* ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Male White Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Anna R. Amos*

6 DATE OF BIRTH (month, day, and year)

*Jan. 6, 1863*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*65 2 15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.*Manager Amos Bldg.*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore, Md.*

10 NAME OF FATHER

*Thomas R. Rich*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Baltimore, Md.*

12 MAIDEN NAME OF MOTHER

*Elizabeth Wilson*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore, Md.*

14

Informant  
(Address)*Mrs. Anna R. Rich  
3200 Clifton Ave.*

15

Filed

AR 23 1928. C. N. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/21/28*

17

I HEREBY CERTIFY, That I attended deceased from

*3-4, 1928, to 3-21, 1928.*that I last saw him alive on *3-21, 1928.*and that death occurred, on the date stated above, at *6:46 p.m.*

The CAUSE OF DEATH\* was as follows:

*Excessively small intestine*CONTRIBUTORY (Secondary) *Peritonitis plus myocardial  
failure* (duration) ? yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *Yes* Date of *3-6-28*Was there an autopsy? *No* *3-21-28*What test confirmed diagnosis? *Pathological diagnosis*(Signed) *W. G. Gammie, F.R.C.S.* M. D.19 (Address) *Chesapeake & Annapolis*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Green Mount Cemetery, March 24, 1928*

20 UNDERTAKER

ADDRESS

*John C. Mitchell & Sons 1900 Clifton Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31968

## CERTIFICATE OF DEATH.

101-001  
E 31968

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409-N-Calver ST. 19-76 WARD)2-FULL NAME Donald Stanley Johnson(a) RESIDENCE NO. 409-N Calver ST.

(Usual place of abode)

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX m4 COLOR OR RACE C5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22, 1913

7 AGE

Years

Months

Days 29

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work base player

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.10 NAME OF FATHER Charles Johnson11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.12 MAIDEN NAME OF MOTHER Naomi Johnson13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14

Informant (Address) Charles Johnson  
409-N. Calver St.

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1928

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1927, to March 20, 1928that I last saw alive on March 20, 1928and that death occurred, on the date stated above, at 3 34 pm

The CAUSE OF DEATH\* was as follows:

Aspir pneumonia(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Aspir pneumoniaDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Aspir pneumonia(Signed) W. A. Jones, M. D.19 (Address) 111 S. Liberty

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

111 S. Liberty March 23, 1928

20 UNDERTAKER

ADDRESS

W. A. Jones111 S. Liberty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AR 23 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31969

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 W. Lombard

## 2-FULL NAME

Joseph L. Harden

## (a) RESIDENCE. NO.

1231 W. Lombard

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

mos.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

31969

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary E. Harden

## 6 DATE OF BIRTH (month, day, and year)

Mar 21 1860

## 7 AGE

68

Years

Months

21

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Fireman

## (b) General nature of industry, business, or establishment in which employed (or employer)

Don't know

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

VA

## 10 NAME OF FATHER

Don't know

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

VA

## 12 MAIDEN NAME OF MOTHER

Mary E. Harden

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

VA

## 14

## Informant (Address)

Joseph Harden

1231 W. Lombard

## 15

## Filed

23 1928

C. HAMMON JONES, M. D.

Reg.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1928

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1928, to March 21, 1928,

that I last saw him alive on March 21, 1928,

and that death occurred, on the date stated above, at 12:40 A.M.

The CAUSE OF DEATH\* was as follows:

Carditis

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physique signs

(Signed) W. S. Dissect M. D.

19 (Address) 1324 W. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore

## DATE OF BURIAL

March 24 1928

## 20 UNDERTAKER

John Fields 1200 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31970 (Henry)

CERTIFICATE OF DEATH.

188-003

E 31970

1-PLACE OF DEATH

City of BALTIMORE: (Name of Hospital, Institution, or Place)

2-FULL NAME *H. Carroll Manchester*

(a) RESIDENCE NO. *221 E. Biddle* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred *73 yrs. 2 mos. 0 ds.* How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 1 Color or Race *W.* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Wife H. C. Manchester*

6 DATE OF BIRTH (month, day, and year) *Jan 21, 1875*

7 AGE Years *73* Months *2* Days *0* IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *Bal to*

10 NAME OF FATHER

*Alexander Manchester*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Bal to*

12 MAIDEN NAME OF MOTHER

*Sarah Carroll*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Bal to Co Ind*

14 Informant *Henry Carroll*  
(Address) *221 E Biddle St.*

15 Filed *1925* Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/21 1925*

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
*Compound fracture, Tibia & Fibula - Acc to Accident*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *Progressive pneumonia*  
(Signed) *John H. Morrison* M. D.  
(Coroner)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Immanuel Churchyard* Date of Burial *Mar 23 1925*

20 UNDERTAKER *Henry H. Jenkins Sons & Co* ADDRESS *300 E. Charles St.*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 23 1925

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31971

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 31971

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward 24-34)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Mary M. Lowery.

(a) RESIDENCE NO. 1508 Riverside Ave.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 11 mos. 13 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White.

Married.

6a If married, ~~XXXXXXXXXX~~

(or) WIFE of

Lawrence A. Lowery

8 DATE OF BIRTH (month, day, and year)

April 7, 1907

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

20

11

13

## 9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

10 BIRTHPLACE (city or town).....

(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Carl Johnson.

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Edna Manley.

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Baltimore, Md.

14

Informant Lawrence Lowery (husband)(Address) 1508 Riverside Ave.15 Filed 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 20, 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiryand that said deceased came to her death  
(Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Concussion of the brain

Automobile collision.

Probably accidental.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) [Signature]M. D.  
(Coroner)3/22 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Liberty Road Carroll Co. Md. March 18, 1928

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR

REMOVAL

Date of Burial

St. Olmsted Cemetery3/23/1928

20 UNDERTAKER

ADDRESS

E. O. Panning, Inc. - 140 Battery Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 31972

## HEALTH DEPARTMENT-CITY OF BALTIMORE ✓

E 31972

## CERTIFICATE OF DEATH

101-001

## 1-PLACE OF DEATH

City of BALTIMORE: (No.)

3215 Barclay St. 12-50 Ward

## 2-FULL NAME

Augustus Amos

## (a) RESIDENCE NO.

3215 Barclay St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 Color or Race

col

## 5 Single, Married, Widowed, or Divorced. (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct 9th 1927

## 7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

5

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Maryland

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Ethel Amos

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

## 14

Informant (Address)

Ethel Amos 3215 Barclay St.

## 15 FILE

MAR 23 1928

C-19

S. J. JONES, R. D.

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3-21-28

19

## 17

HEREBY CERTIFY, That I attended deceased from

3/21, 1928, to 3/22, 1928,

that I last saw him alive on 3/21, 1928,

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Labor pneumonia

(duration) yrs. mos. da.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

## 18 Where was disease contracted

If not at place of death?

3215 Barclay

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. J. Jones, M. D.

19 (Address) 1618 Calver

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mount Auburn

Mar. 23, 1928

## 20 UNDERTAKER

Mrs. R. G. Elliott

ADDRESS

123 Ashland

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31973

CERTIFICATE OF DEATH.

REGISTERED NO.

E 31973

1-PLACE OF DEATH

City of BALTIMORE: (No. 1042 Shind Alley 7-24 Word)

2-FULL NAME

(a) RESIDENCE NO. 1042 Shind Alley

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was known:

Septic Peritonitis  
Rupture of Prostate

CONTRIBUTORY (Secondary)

Mar 22/28 Chadler mos. ds.

22/28 Chadler M. D.

19 (Address) 143 16 Wm

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Other Disposition

St. Luke's 3/23/28

20 UNDERTAKER

St. Luke's 3/23/28

MAR 23 1928

JOHN JONES

St. Luke's 3/23/28



E 31974

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31974

## CERTIFICATE OF DEATH.

100-002  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 543 Moon St. 17-24 Ward 17-24)2-FULL NAME Doris Seard(a) RESIDENCE NO. 543 Moon

(Usual place of abode)

Length of residence in city or town where death occurred. Life yrs. mos. ds.St. 17-24 Ward 17-24

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18-1917

7 AGE

Years

Months

Days

IF LESS than 1 day, hrs. or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore10 NAME OF FATHER Wm Seard

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore12 MAIDEN NAME (if mother) Pauline Taylor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) MD

14

Informant

(Address) 543 Moon St.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said Inquiry and that said deceased came to Accident death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cap. Bronchitis

CONTRIBUTORY (Secondary)

Mar 22 1928 (duration) yrs. mos. ds. 1 (Signed) R. A. Austin (Coroner) 143 761 Bay (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL or CREMATION Date of Burial

20 CERTIFIER

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 23 1928

Registrar

578 N. Holliston St.  
Samuel H. Hunsley

E 31975

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31975

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. *Temple Garden Apt. 2-47* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *M. Maurice Meyer*(a) RESIDENCE NO. *Temple Garden Apt. #101* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Lifetime*

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Betha Meyer*6 DATE OF BIRTH (month, day, and year) *March 8, 1880*7 AGE Years *48* Months *0* Days *13* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Attorney*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Bald.* (State or country) *Md.*10 NAME OF FATHER *Gerson Meyer*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Mina Stern*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Mrs. C. Newman* (Address)15 *MAR 23 1928*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/21/1928*17 I HEREBY CERTIFY, That I attended deceased from *Jan 23, 1928*, to *March 21, 1928*, that I last saw him alive on *March 21, 1928*, and that death occurred, on the date stated above, at *11 A. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic nephritis - diabetes*(duration) *5* yrs. mos. ds.CONTRIBUTORY (Secondary) *Myocarditis + anemia* (duration) yrs. mos. *14* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical* (Signed) *J. Frederick Lutz* M. D.3-21-1928 (Address) *Temple Garden Apt.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Hebrew Friendship Cem.**3/23/1928*

UNDERTAKER

ADDRESS *118 20 W. Mt. Royal Ave.*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31976

## CERTIFICATE OF DEATH.

E 31976

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 734 N. Fulton Ave. St., 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Jane Phelps

(a) RESIDENCE NO. 734 N. Fulton Ave. NSL Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Byron Phelps

6 DATE OF BIRTH (month, day, and year)

September 1, 1856

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

71 6 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Charles Turner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Ethel Crouch (Address) Edgewood, Md.

15 Filed....., 19.....

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

March 22, 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

3/22, 1928 (Address) 143 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Western Cemetery

Mar. 24 1928

20 UNDERTAKER

ADDRESS 1003 West Baltimore

E 31977

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 W. Lexington

2-FULL NAME Margaret F. Hoffman

(a) RESIDENCE No. 1902 W. Lexington

(Usual place of abode)

Length of residence in city or town where death occurred

62

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.,

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Charles T. Hoffman

6 DATE OF BIRTH (month, day, and year) October 20, 1845

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

82

5

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Towson

Maryland

10 NAME OF FATHER James H. Boyd

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Towson

Maryland

12 MAIDEN NAME OF MOTHER (?)

Floyhart

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Towson

Maryland

14

Informant  
(Address)Mrs. Fannie E. Sweeney  
1902 W. Lexington Street

15

Filed

MAR 23 1928

J. M. Jones, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
July 15, 1927, to March 2, 1928,  
that I last saw her alive on March, 19 28,

and that death occurred, on the date stated above, at 12.13 A. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma. Uterus.

(duration)

yrs.

8 mos

ds.

CONTRIBUTORY  
(Secondary)

Gen Infection of Vagina

+ Pelvic Infection

(duration)

yrs.

2 mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex

(Signed)

J. M. Lempert

M. D.

3/22/28 (Address) 3409 Callaway Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Mt. Oliver

Mar. 24 19 28

UNDERTAKER

ADDRESS

1003 West  
Baltimore St



212624  
E 31978

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

327 E 31978

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)2. FULL NAME Willis Williams(a) RESIDENCE NO. 1410 May

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

malecoloredSingle5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of6 DATE OF BIRTH (month, day, and year) 11-1-24

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.3--21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

MAR 23 1928

ST. 5-9

WARD)

ST.

WARD

(If non-resident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 12, 1928, to Mar 22, 1928,that I last saw him alive on Mar 22, 1928,and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH\* was as follows:

Tuberculous meningitis.

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)Mediastinal tuberculosis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Bennett

M. D.

Mar 22, 1928

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

Edmund Bryson

ADDRESS

1631 arleons

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
E 31979

CITY OF BALTIMORE: (No. 3025 Westwood ST. 15-61 WARD)

2-FULL NAME Margaret E. Leineweb

(a) RESIDENCE NO. 3025 Westwood ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11 1874

7 AGE Years 54 Months — Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work  
(b) General nature of industry, business, or establishment in which employed (or employer) at Home  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER W. A. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ruppel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant W. E. Leineweb  
(Address) 3025 Westwood St.

15 Filed MAR 23 1928 C. HANCOCK JONES, R. Registrar

REGISTERED NO. 9E 31979

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1928

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1928, to March 21, 1928.

that I last saw her alive on March 21, 1928, and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis  
Duration from history about 6 mo.CONTRIBUTORY (Secondary) Myocarditis about 6 mo.  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. S. Hibbitt, M. D.

4/22/28 (Address) 2220 Garrison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER  
Zion Park Bur. Mar 24 1928  
H. M. Rounton  
ADDRESS 2205 N. 17th

E 31980

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31980

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1441 Howman* ST. *15-22* WARD)

## 2. FULL NAME

*Mary Ann Pryal*(a) RESIDENCE No. *1441 Howman*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Edis Pryal*

6 DATE OF BIRTH (month, day, and year)

*Jan 2, 1857*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*71**2**20*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Homemaker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*Harry Karp*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Poland*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Poland*

14 Informant (Address)

*Mr. Harry Pryal  
1441 Howman St*

15

MAR 23 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 22, 1928*

17

HEREBY CERTIFY, That I attended deceased from *Feb. 1, 1928* to *March 22, 1928* that I last saw her alive on *March 22, 1928* and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH\* was as follows:

*Generalized Arterio-sclerosis, nephritis, myocarditis*CONTRIBUTOR (Secondary) *Cerebral Hemorrhage*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical exam.*(Signed) *J. Edward Nemo*, M. D.  
Address *107 East West St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Mar. Calhoun*

DATE OF BURIAL

*March 26, 1928*

20 UNDERTAKER

*Chas. H. Stevens*

ADDRESS

*1501  
2nd St. N.W.*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 31981 HEALTH DEPARTMENT—CITY OF BALTIMORE E 31981

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Beechdale Road, ~~27-53~~ ~~27-53~~)

## 2-FULL NAME

Addie M. Fleet

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

210 Beechdale Road

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Charles Temple Fleet

## 6 DATE OF BIRTH (month, day, and year) May 18, 1860

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

67

10

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Somerset County  
Maryland

## 10 NAME OF FATHER George T. Dorman

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Somerset Co  
Maryland

## 12 MAIDEN NAME OF MOTHER Mary E. Miles

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Somerset Co  
Maryland

## 14

Informant

(Address)

Clarence B. Marchant  
210 Beechdale Road

## 15

Filed

19

MAR 23 1928

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) March 22, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from  
March 18, 1926, to March 21, 1928.

that I last saw her alive on March 21, 1928.

and that death occurred, on the date stated above, at 12:10 A.M.

The CAUSE OF DEATH\* was as follows:

Myocarditis  
(auricular fibrillation)

at least— (duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY  
(Secondary)Chronic Intestinal hepatitis with  
inflammation (duration) yrs. 2 mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

## What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Loudon Park Cemetery

## DATE OF BURIAL

3/24, 1928

## 20 UNDERTAKER

## ADDRESS

Henry W. Mears Son 805 N. Calvert



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

212092  
E 31982

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITALST., 8-13 WARD)REGISTERED NO. 31982

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Margaret Sommer(a) RESIDENCE NO. 1201 N. Caroline

(Usual place of abode)

ST., \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, ~~Married~~, ~~Widowed~~,  
or ~~Divorced~~ (write the word)Female WhiteSingle5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Apr. 11-1898

7 AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.791111

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workHousewife(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town,  
(State or country) Ind.10 NAME OF FATHER John Sommer11 BIRTHPLACE OF FATHER (city or town,  
(State or country) Holland

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (city or town,  
(State or country) \_\_\_\_\_

14

Informant Beards  
(Address) \_\_\_\_\_

15

Filed

19

Registrar R. H. H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar-22-1928

17

HEREBY CERTIFY, That I attended deceased from  
Mar-14-1928 to Mar-22-1928,  
that I last saw him alive on Mar-22-1928,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH\* was as follows:

Hematuria (Cause unknown)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

CONTRIBUTORY  
(Secondary) Secondary anemia.(duration) 10 yrs. \_\_\_\_ mos. \_\_\_\_ ds.18 Where was disease contracted  
if not at place of death? Baltimore.Did an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Urine & blood exams.  
(Signed) Robt. L. Faulkner, M. D.3/22, 1928 (Address) Johns Hopkins Hosp.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALLondon Park Cemetery

DATE OF BURIAL

3/24 1928

UNDERTAKER

George W. Zirkler

ADDRESS

1737 E. Eager St

E 31983

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 E. 29<sup>th</sup>)

2-FULL NAME Warren V. Collier

(a) RESIDENCE No. 1821 E. 29<sup>th</sup>

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos.

ST., WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Madeline R. Collier

6 DATE OF BIRTH (month, day, and year) Apr. 19-1890

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min

37

11

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Advertiser

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Phila, Pa.

10 NAME OF FATHER

Joshua Collier

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Del.

12 MAIDEN NAME OF MOTHER

Mary Hopkins

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Del.

14

Informant  
(Address)

Madeline R. Collier

1821 E. 29<sup>th</sup> St.

15

Filed

MAR 23 1928

JONES, R. J.

Registrar

UNDERTAKER

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

New Cathedral Cem.

George W. Zinkler

DATE OF BURIAL

3/24 1928

ADDRESS

1737 E. Caga  
st.

REGISTERED NO. E 31983

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

9-46

74-001

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1928

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1-1927, to March 21-1928.

that I last saw him alive on March 21-1928.

and that death occurred, on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH\* was as follows:

Is Cerebral Hemorrhage

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Redick W. Hummer

Mar 21 1928 7913 E. Balt. St.

\*State the Disease Causing Death, or in deaths from Violent Cause,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 31984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 31984

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4103 Boarman Ave. 15-63 ST. WARD)

2-FULL NAME Frances Simms

(a) RESIDENCE NO. 4103 Boarman Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. Wm. S. Simms.

6 DATE OF BIRTH (month, day, and year) Aug 1<sup>st</sup> 1865

7 AGE Years 62 Months 7 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va. (State or country)

10 NAME OF FATHER Christopher Tyler

11 BIRTHPLACE OF FATHER (city or town) Virginia. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown. (State or country)

14 Informant John Davis Barker (Address) 1730 Cedar Grove

FILED MAR 23 1928 G. S. JONES, R. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21<sup>st</sup> 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar. 6<sup>th</sup> 1928, to Mar. 21<sup>st</sup> 1928, that I last saw her alive on Mar. 21<sup>st</sup> 1928, and that death occurred, on the date stated above, at 11.26 P. m.

The CAUSE OF DEATH\* was as follows: Arterio Sclerosis with Chronic Myocarditis and Edema of Brain.

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Isaac Edickson M. D.

Mar. 24 1928 (Address) 3055 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Druid Ridge Cemetery Mar 24 1928

UNDERTAKER Robert Brockeson ADDRESS Calhoun Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

2117 E 631985 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

129

E 31985

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL)

ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. V. Clark

(a) RESIDENCE NO. 1012 Lamont Avenue ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15-1896

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 32 2 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

10 NAME OF FATHER Charles Tracey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Mary Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Records (Address)

15 Filed 7-19-28 19 JOHN J. JONES, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar-3, 1928, to March 22, 1928, that I last saw him alive on March 22, 1928,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

① Cerebral Hemorrhage ② Rt. Hemiplegia ③ Chronic nephritis ④ Hypertension ⑤ Anemia

(duration) chronic yrs. 10 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) lasted yrs. 5-10 mos. 0 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood chemistry. Autopsy (Signed) Dr. Christopher Johnston, M. D.

3-22-1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery March 24-28

UNDERTAKER

ADDRESS

Clark & Son 1442



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 31986

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)

## 2-FULL NAME

Everett Robinson

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

ST.

WARD

How long in U. S. if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widower

## 5a If married, widowed, or divorced

HUSBAND ofWIFE ofSue Robinson

## 6 DATE OF BIRTH (month, day, and year)

Aug 15 - 1860

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.6777

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Dr. Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Maryland

## 10 NAME OF FATHER

Marcellus Robinson11 BIRTHPLACE OF FATHER (city or town)  
(State or country)MD

## 12 MAIDEN NAME OF MOTHER

Don't know13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)MD

## 14

Informant  
(Address)Records

## 15

Filed

Mar 24 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 8, 1928, to Mar 22, 1928.that I last saw him alive on Mar 22, 1928.and that death occurred, on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia  
(Carcinoma of Prostate)

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

yes

Date of

Nov 12

Was there an autopsy?

yes

What test confirmed diagnosis?

Microscopy P. M.

(Signed)

Robert J. Targus

M. D.

3/22, 1928 (Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

London Park CemeteryMarch 24 1928

## 20 UNDERTAKER

Robert J. Targus

## ADDRESS

13 Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31987

## CERTIFICATE OF DEATH

100-001 E 31987

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *100*)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant

(Address)

15

Filed

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
3/13/28, 19 to 3/23/28, 19

that I last saw him alive on 3/22/28, 19

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

Signed

19 28 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31988

## CERTIFICATE OF DEATH

162 E 31988

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *413 W Biddle St.* Ward *6-9*)

## 2-FULL NAME

(a) RESIDENCE NO. *1603 Walter* St. *Walter* Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M*

4 Color or Race

*C*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*3-9-28*

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

*10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore*

10 NAME OF FATHER

*Nelson Johnson*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Dona Anderson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore*

14

Informant (Address)

15 Filed

*C. HANSEN*

R 23 1928

*3088*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 31*19 *28*

17

I HEREBY CERTIFY, That I attended deceased from

*3-9-28*, 19 *28*, to *3-21-28*, 19 *28*that I last saw him alive on *3-21-28*, 19and that death occurred, on the date stated above, at *4:40 p.m.*

The CAUSE OF DEATH\* was as follows:

*Congenital Deletions*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

. 19

(Address)

*J. B. Butler, M. D.**4557 Caroline St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

19

20 UNDERTAKER

ADDRESS

JOHN HOPKINS HOSPITAL

Gen. Missioner Health.

W. H. WOODALL

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26-A Co.-200 Bks.

31989

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hosp*)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *2* mos.

ST.

WARD

(If non-resident give city or town and State)

ds. How long in U. S. if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Informant (Address)

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

I HEREBY CERTIFY, That I attended deceased from

Jan 23, 1928 to Mar 22, 1928

that I last saw her alive on Mar 22, 1928

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH\* was as follows:

Prematurity

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *Prenatal (Maternal)*

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *Margaret B. Ballard*, M. D.19 28 (Address) *Franklin Sq. Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 23 1928

G. HAMMOND JONES, M. D.

MAR 24

JOHNS HOPKINS HOSPITAL

General and Special

MAR 23 1928



E 31990

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 31990

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *605 N. Charles* ST. *11-7* WARD)2-FULL NAME *John M. Heighe*(a) RESIDENCE No. *605 N. Charles* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 *Single, Married, Widowed, or Divorced*, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Sallye Ross Heighe*6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years *86* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Lawyer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md.*

10 NAME OF FATHER

*B. M. Heighe*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore Md.*

12 MAIDEN NAME OF MOTHER

*Anna Berthel*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore Md.*

14

Informant  
(Address)*Sallye Ross Heighe*  
*605 N. Charles St.*

15

23 1928

*C. H. AMMON JONES, M. D.*  
*R. H. A.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 22<sup>nd</sup> 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 1*, 1927 to *Mar. 22*, 1928.that I last saw him alive on *Mar. 22*, 1928.and that death occurred, on the date stated above, at *11.25 P. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma Liver*(duration) *2* yrs. *2* mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Prager-Brown-Lundberg*

(Signed)

*James C. Clarke* M. D.(Address) *Latrobe Apt.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Greenmount Cem**March 24 1928*

20 UNDERTAKER

ADDRESS

*Henry Jenkins & Sons Co**Orchard*  
*46 Colloche St.*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 31991

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31991

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hosp 15-64* ST. *45* WARD)

## 2-FULL NAME

*Matilda B TITTER*

## (a) RESIDENCE NO.

*3821 - Forest Park Ave.*

## WARD

*Baltimore Md*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*F*

## 4 COLOR OR RACE

*W*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced

(or) WIFE of

*George Titter*

## 6 DATE OF BIRTH (month, day, and year)

*Aug 14, 1867*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*60**7**8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Delaware*

## 10 NAME OF FATHER

*James Patterson*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*N.J.*

## 12 MAIDEN NAME OF MOTHER

*Mary Bateman*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Delaware*

## 14

Informant  
(Address)*Deceased George Titter  
3821 Forest Park Ave*

## 15

Registrar

*C. HANCOCK JONES, M.D.  
RCA*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 22, 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from  
*March 8, 1928, to March 22, 1928*that I last saw her alive on *March 22, 1928*and that death occurred, on the date stated above, at *3:03 P.M.*

The CAUSE OF DEATH\* was as follows:

*General Carcinomatosis - peritoneum*(duration) yrs. *1* mos. ds.CONTRIBUTORY  
(Secondary)(duration) yrs. *2* mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *Yes* Date of *March 16, 1928*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. S. Hannan* M. D., 19 (Address) *Union Memorial Hospital  
330 a Calvert St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

*Chesapeake City Md.**Mar 25, 1928*

## 20 UNDERTAKER

## ADDRESS

*Wm. J. Schuler Sons**North Sta*

Physicians should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 23 1928

E 31992

## HEALTH DEPARTMENT—CITY OF BALTIMORE, E 31992

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 E. Garrison Lane 20-69 WARD)2-FULL NAME Sarah Frances Swann(a) RESIDENCE No. 305 E. Garrison Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of or WIFE of George Swann6 DATE OF BIRTH (month, day, and year) Sept. 22<sup>nd</sup> 1847

7 AGE

Years 80Months 6Days 0

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince William Co., Virginia10 NAME OF FATHER Cornell11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown12 MAIDEN NAME OF MOTHER Lovellace13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14

Informant Mrs. Maggie Myers(Address) 305 E. Garrison Lane

15

Filed 23 1928

19

BALTIMORE

JONES, R

Registrar

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22<sup>nd</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from June, 1928, to 22 Mar, 1928that I last saw her alive on 22 Mar, 1928, and that death occurred, on the date stated above, at 7:55 P m.

The CAUSE OF DEATH\* was as follows:

Arterio sclerosis(duration) 4 yrs. mos. ds.CONTRIBUTORY (Secondary) Myocarditis(duration) yrs. mos. ds. 10

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓Was there an autopsy? NoWhat test confirmed diagnosis? No(Signed) W. H. H. H. H. H., M. D.23<sup>rd</sup> 1928 (Address) 2565 Ford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Agnes, MdDATE OF BURIAL 3rd 192820 UNDERTAKER St. Agnes, MdADDRESS St. Agnes, Md

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

E 31993

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31993

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3624 Greenmount Ave* ST. *76-37* WARD *90*)

## 2-FULL NAME

CHARLES HENRY ROLOSON

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*3624 Greenmount Ave*

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

*74* yrs. *10* mos. *1* ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male white**widowed*

5a If married, widowed, or divorced

HUSBAND of  
or) WIFE of*FRANCES ALBERT ROLOSON*

6 DATE OF BIRTH (month, day, and year)

*May 20<sup>th</sup> 1853*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.*74**10**1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*10 NAME OF FATHER *FREDERICK ROLOSON*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *ELIZA TIMANUS*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Unknown*

14

Informant  
(Address)*Charles Henry Roloson Jr*  
*3624 Greenmount Ave*

15

Filed

19

AR 23 1928

Register

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 21 1928*

17

HEREBY CERTIFY That I attended deceased from

*Feb 5 1928* to *March 21 1928*

that I last saw him alive on

*Mar - 21 1928*

and that death occurred, on the date stated above, at

*6 P. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Endocarditis, Mitral Insufficiency*(duration) *5* yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. *5* ds.18 Where was disease contracted  
if not at place of death?*No*

Did an operation precede death?

*No*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Physiological*

(Signed)

*W. Gibson Porter*, M. D.

3/23, 1928

(Address) *422 Roland Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*New Cathedral Ave**Mar 24 1928*

20 UNDERTAKER

ADDRESS

*Wm J. Liskner Sons**North Va*



E 31994

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 E 31994

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame 16-14 ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Simona Dichtmayer

(a) RESIDENCE NO. 1109 1/2 St.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov - 18 - 1861

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

66

4

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 18

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rochester N. Y. (State or country)

10 NAME OF FATHER George Dichtmayer

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Ottilia Matern

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Sister Mary Dionide (Address) 1109 1/2 St. City

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March - 22 - 1928

17

I HEREBY CERTIFY, That I attended deceased from May - 10 - 1923, to Mar - 22 - 1928, that I last saw her alive on March - 22 - 1928, and that death occurred, on the date stated above, at 7.45 p. m. The CAUSE OF DEATH\* was as follows:

carcinoma colon

(duration) 5 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 21, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Physical evidence.

(Signed) Mrs. B. Dybert M. D.

, 19 (Address) 2802 Harford Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA Notch Cliff Med. March 24 1928

20 UNDERTAKER

ADDRESS

Frank A. Pink 9158 9000

AR 23 1928

19 HAMMOND JONES, M. D. Registrar



E 31996

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 11-00 E 31996

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 S. Charles ST. 23-34 WARD)

2-FULL NAME Anna. Gertrude Kirby

(a) RESIDENCE NO. 1517 S. Charles ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1927

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

9 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant William H. Kirby (Address) 1517 S. Charles

15 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1928

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1928, to March 22, 1928, that I last saw him alive on March 23, 1928, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH\* was as follows:

Brachial pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed)

19 (Address) 1216 N. Waverly

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Brimmes Island

20 UNDERTAKER

Mar 25 1928 ADDRESS

Jas J. Henderson

2172 Pm

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AR 23 1928

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 31997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001  
E 31997

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 E Fort ave

24-33  
ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph S. Brocato

(a) RESIDENCE No. 702 E. Fort ave

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

( mos. 11 )

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 31<sup>st</sup> 1927

7 AGE

Years

Months

Days 21

If LESS than 1 day, hrs. or min.

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Placido Brocato

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Florence Delfonzo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Placido Brocato 702 E Fort ave

15

C. HAMMON JONES, R. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1928, to March 22, 1928, that I last saw him alive on March 22, 1928, and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.

Pneumonia was primary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pessagno, M. D.

3, 23, 1928 (Address) 514 Drury Lane

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

19

20 UNDERTAKER

ADDRESS

Frank V. Pipitone

2815 E. Baltos



E 31998

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31998

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *12-50* ST. *128* WARD)2. FULL NAME *Mary Regina Ward*(a) RESIDENCE No. *333 E 20th*

(Usual place of abode)

Length of residence in city or town where death occurred *53* yrs. *8* mos. *6* ds.

ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Unknown*6 DATE OF BIRTH (month, day, and year) *Aug 15 1874*

7 AGE

Years *53*Months *8*Days *7*If LESS than 1 day, hrs. *6* or min. *5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *None*(c) Name of employer *None*9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *John B. Egerton*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *Mary Regina Fowler*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *St Mary's Co Md*

14

Informant (Address) *10101 Records 12101 Records*

15

File *1928*C-9 *SAMUEL JONES, R. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 20 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 7 1928* to *March 20 1928*that I last saw him alive on *March 20 1928*and that death occurred, on the date stated above, at *8.25 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Parenchymatous Nephritis (Uremic Coma)*CONTRIBUTORY (duration) *1* yrs. *1* mos. *7* ds. *Involutional Depression* (Secondary) (duration) *3* yrs. *1* mos. *7* ds. *Chenier*18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*What test confirmed diagnosis? *Chemical*(Signed) *William P. Bell*, 19 (Address) *10101 Records*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Greenmount Cemetery*DATE OF BURIAL *March 24 1928*20 UNDERTAKER *Mary M. Medfield*ADDRESS *501 E 22nd*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 31999

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31999

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3207 Woodland Ave.

ST. 27-56 WARD)

2-FULL NAME Leslie F. Schwatka,

(a) RESIDENCE NO. 3207 Woodland Ave.

(Usual place of abode)

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 27 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Dora C. Schwatka,

6 DATE OF BIRTH (month, day, and year) January 11, 1901

7 AGE 28 Years Months Days If LESS than 1 day, hrs. or min. 27 2 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Arthur H. Schwatka,

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md. (State or country)

12 MAIDEN NAME OF MOTHER Catherine A. Quinn,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or country)

14 Informant Arthur H. Schwatka (Address) 3207 Woodland Ave.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1928

17 I HEREBY CERTIFY, that I attended deceased from Nov 12, 1927, to March 21, 1928, that I last saw him alive on March 21, 1928, and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH\* was as follows:

Tubercular Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Woodlawn

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

23 1928

C. HAMMOND JONES, R. D. Registrar

E 32000

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32000

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apts. 4 A. ST. 13-54 WARD 49)2-FULL NAME Sody Salabes(a) RESIDENCE NO. Esplanade Apts. 4 A. ST. 13-54 WARD 49

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ettie Salabes6 DATE OF BIRTH (month, day, and year) Dec. 5th. 18457 AGE Years 82 Months 3 Days 18 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Pawn Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Holland10 NAME OF FATHER Meyer Salabes11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland12 MAIDEN NAME OF MOTHER Marianna Snyder13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland14 Informant Dr. Lewis Hess,  
(Address) 1725 Entw Place15 23 1928 C. SAMSON JONES, N. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23rd. 19 28

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to March 23, 1928.  
that I last saw him alive on March 22, 1928  
and that death occurred, on the date stated above, at 8<sup>30</sup> A. m.

The CAUSE OF DEATH\* was as follows:

Prostatic Carcinoma, adenitis  
sclerosis, Chronic Nephritis  
uraemia(duration) 1 yrs. — mos. — ds.CONTRIBUTORY (Secondary) Myocarditis & Pulmonary  
Edema(duration) 0 yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friedman, M. D.  
19 (Address) 1013 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto. Hebrew Cem.

DATE OF BURIAL

3/25/ 19 28

20 UNDERTAKER

David Sandheim

ADDRESS

118-20 W. Mt. Royal Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32001

## CERTIFICATE OF DEATH.

E 32001

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2306 Ken oak St. 97-55 Ward)2-FULL NAME Virginia F. Foster(a) RESIDENCE No. 2306 Ken oak St. 97-55 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow6a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C. Foster6 DATE OF BIRTH (month, day, and year) October 9 18507 AGE Years 77 Months 5 Days 12 12 LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fairfax Court House Va. (State or country)10 NAME OF FATHER Wm Wright11 BIRTHPLACE OF FATHER (city or town) New York (State or country)12 MAIDEN NAME OF MOTHER Eynthia L. L...13 BIRTHPLACE OF MOTHER (city or town) New York (State or country)14 Informant Philip E. Edwards (Address) 2306 Ken Oak Av15 Filed 1925 Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) had that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Salvador disease of heart (duration) ..... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

(Signed) John H. Hensley (Coroner) M. D.(Address) 8522 Roland

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St O Crvet Cemetery March 2820 UNDERTAKER Geo W Little ADDRESS 2708 Edmondson Av

N. B.—WRITE PLAINLY, with ink, and in plain terms, so that it may be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificate.



E 32002

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32002

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1921 W Fayette* ST. *70-27* WARD)2-FULL NAME *Jeresa Hoffman*(a) RESIDENCE No. *1921 W Fayette* ST., *70-27* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced *Married* (Write the word)5a If married, widowed, or divorced HUSBAND of (or) WIFE of *G. E. Hoffman*6 DATE OF BIRTH (month, day, and year) *Jan 7 1856*7 AGE Years *72* Months *2* Days *14* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Michael Thomas*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Margaret Blum*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

14

Informant (Address) *Mr. J. Hoffman*  
*921 W Fayette*

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *21 March 1928*17 I HEREBY CERTIFY, That I attended deceased from *Jan.* 1925, to *March 21* 1928.that I last saw her alive on *March 16* 1928,and that death occurred, on the date stated above, at *7:30 P. M.*

The CAUSE OF DEATH\* was as follows:

*Uremic delirium.**Hypertension.*(duration) *5* yrs. *7* mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *1* yr. *1* mo. *1* ds.18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *Stanley Green* M. D.1928 (Address) *11 W. Fayette*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Cathedral Cem*DATE OF BURIAL *3 Apr 28*20 UNDERTAKER *John Farley Fulton*ADDRESS *Fayette*

N. B.—WRITE PLAINLY. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

AR 23 1928

C. HANCOCK JONES, M. D. Registrar  
P. H. H.

32003

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32003

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

Union Memorial Hosp.

ST.

WARD)

## 2-FULL NAME

James Albert Robins

(a) RESIDENCE NO.

6 Stone Ave.

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Catharine St.

(Usual place of abode)

Length of residence in city or town where death occurred

0

yrs.

0

mos.

4

ds.

How long in U. S., if of foreign birth?

62

yrs.

7

mos.

27

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mrs. J. A. Robins

6 DATE OF BIRTH (month, day, and year)

July 24, 1885

7 AGE

Years

62

Months

7

Days

27

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Paper Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

Paper

(c) Name of employer

Self.

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Albert Robins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Deceased

15

1928

G. HAMMON JONES, R. J.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 18, 1928, to March 22, 1928,

that I last saw him alive on March 22, 1928,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Cancer - Esophagus.

CONTRIBUTORY (Secondary)

(duration) yrs. ? mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Yes Date of March 21, 1928

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) J. J. Prosser M. D.

19 (Address) Union Memorial Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

London Park Cemetery May 1928.

20 UNDERTAKER

ADDRESS

Stewart &amp; Son Baltimore Md

mation should be carefully read, so that it may be properly filled in. See instructions on back of certificates.

AR 23 1928

E 32004

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32004

CERTIFICATE OF DEATH. *X 38*

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *11-24* ST. *11-24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Anderson Green*(a) RESIDENCE NO. *801* *Hamilton* *St.* WARD *Corn.*  
(Usual place of abode)

Length of residence in city or town where death occurred

*10* yrs. *6* mos. *0* ds.How long in U. S., if of foreign birth? *28* yrs. *3* mos. *27* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male**white**single*5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of*single*

6 DATE OF BIRTH (month, day, and year)

*Nov-25-1899*

7 AGE

Years

Months

Days

If LESS than  
1 day.....hrs.  
or.....min.*28**3**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Connecticut*

10 NAME OF FATHER

*Daniel Green*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*England*

12 MAIDEN NAME OF MOTHER

*Esther Buckman*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Connecticut*

14

Informant  
(Address)*Records*

15

Filed

*G. HANCOCK JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/23/1928*

17

I HEREBY CERTIFY That I attended deceased from

*Dec. 7, 1928, to Mar. 23, 1928.*that I last saw him alive on *Mar. 23, 1928.*and that death occurred, on the date stated above, at *8:00 A. M.*

The CAUSE OF DEATH\* was as follows:

*Exfoliative dermatitis of  
arsenical origin.**Decubitus ulcers.*(duration) yrs. *2* mos. ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. *2* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *General + Sub*(Signed) *C. J. Delmonico Boyd*, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*New York - N.Y.**Mar 24/1928*

20 UNDERTAKER

ADDRESS

*Stewart Monro & Co.*

Information should be given in plain terms, so that it may be understood. See instructions on back of certificates.

MAR 23 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32005

E 32005

## CERTIFICATE OF DEATH.

101-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hosp 26-37* ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Elizabeth Schaper*(a) RESIDENCE NO. *570 Ave T 26* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. mos. ds.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Charles E Schaper*6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*About 59*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*S. C.*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*S. C.*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*S. C.*

14

Informant (Address)

*Charles J. Hallman 4002 N. Raymond Ave*

15

AR 24 1928

*W. J. Jones, A. L.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 21 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 15, 1928* to *March 21, 1928*, that I last saw her alive on *March 21, 1928*,and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

*Acute Cardiac* (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*Home*Did an operation precede death? *no* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy*(Signed) *Lawrence F. Hickey*, M. D., 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park**3/24 1928*

20 UNDERTAKER

ADDRESS

*W. J. Cook**502 E. North Ave*

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates.



E 32006

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32006

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals (T. 4725 ST. 4725 WARD 31)2-FULL NAME Lillian Allen

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 678 W. Fayette st.ST.          WARD         

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18757 AGE Years 53 Months          Days          If LESS than 1 day, hrs.          or min.         

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Thomas Ashworth11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Sally Peddy13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 Informant Hospital Records (Address)15 Filed 24 1928 C. HAMPTON JONES, R. R. P. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 192817 I HEREBY CERTIFY, That I attended deceased from March 13, 19 28, to March 22, 19 28.that I last saw her alive on March 22, 19 28.and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH\* was as follows:

Pul. Heambrose (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of         Was there an autopsy? NoWhat test confirmed diagnosis? clinical (Signed) L. E. Madden, M. D.3-22, 1928 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

St Marys Nonpden3/26 1928

20 UNDERTAKER

ADDRESS

W. M. Cook507 E North

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

E 32007

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

46 E 32007

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 South Bouldin ST. 1-76 WARD)2-FULL NAME Carrie BetzoldREGISTERED NO. \_\_\_\_\_  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)(a) RESIDENCE NO. 307 South Bouldin ST. WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred Life yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed,  
or Divorced, (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofCharles Betzold6 DATE OF BIRTH (month, day, and year) Nov 3-18657 AGE Years 62 Months 4 Days 20 If LESS than  
1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workAt Home(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore Md  
John Herzog

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Europe12 MAIDEN NAME OF MOTHER Annice Miller13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Europe14 Informant Mrs M. Rupp  
(Address) 416 N. Belnord Ave15 24 1928 24 1928 24 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23 192817 I HEREBY CERTIFY, That I attended deceased from  
Dec 23, 1927, to March 23, 1928,  
that I last saw her alive on March 22, 1928,  
and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH\* was as follows:

Recurrent carcinoma in  
the Pelvis - Portion at JKA  
Dyscrasia (duration) yrs. 3 mos. \_\_\_\_\_ ds. \_\_\_\_\_CONTRIBUTORY  
(Secondary)

(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

18 Where was disease contracted  
if not at place of death?Did an operation precede death? \_\_\_\_\_ Date of about 20 yrsWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Col. W. H. Hickey, M. D.  
Nov 23, 1927 (Address) 1008 Patterson Park\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALHoly Redeemer DATE OF BURIAL 3/27 192820 UNDERTAKER William Cook ADDRESS 702 E. N. AveInformation should be carefully  
CAUSE OF DEATH in plain terms, so that it may be properly  
TION is very important. See instructions on back of certificates.

E 32008

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129E 32008

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Lauretta Ave ST 10-69 WARD)2-FULL NAME Mary C Reynolds(a) RESIDENCE NO. 2319 Lauretta Ave ST., WARD

(Usual place of abode)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofRichard T. Reynolds6 DATE OF BIRTH (month, day, and year) Nov 30 - 18527 AGE Years 75 Months 3 Days 23 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Ind  
(State or country)10 NAME OF FATHER William Johnson11 BIRTHPLACE OF FATHER (city or town) Baltimore Ind  
(State or country)12 MAIDEN NAME OF MOTHER Mary Roberts13 BIRTHPLACE OF MOTHER (city or town) Baltimore Ind  
(State or country)

14

Informant Clarence H. Reynolds  
(Address) 2319 Lauretta Ave

15

Filed 1928 19 24 Registrar R.R. Jones

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23-1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1928, to Mar 23, 1928, that I last saw her alive on Mar 22, 1928and that death occurred, on the date stated above, at 8:54 m.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical(Signed) Clarence H. Reynolds M. D.19, 1928 (Address) 701 E. Howard Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cemetery3/26 1928

20 UNDERTAKER

ADDRESS

William Cook502 E. North Ave

Information should be carefully read in plain terms, so that it may be properly understood. See instructions on back of certificates.

E 32009

HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.

E 32009

## 1. PLACE OF DEATH

CITY OF BALTIMORE: No. 162 N. Polowae

2. FULL NAME Joseph Mauer

(a) RESIDENCE NO. 162 N. Polowae

(Usual place of abode)  
Length of residence in city or town where death occurred

ST. 6-11 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Elva

6 DATE OF BIRTH (month, day, and year)

June 29 1863

7 AGE

Years

Months

Days

67

8

24

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Balt. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt. Smith

12 MAIDEN NAME OF MOTHER

Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt. Smith

14 Informant (Address)

Mrs. Elva Mauer

15

Filed

19

Registrar

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Died 25 1928

I HEREBY CERTIFY, That I attended deceased from March 22, 1928, to March 23, 1928, that I last saw him alive on March 23, 1928, and that death occurred, on the date stated above, at 3 a. m. The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

(duration) yrs. mos. ds.

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

Philippus Artigian, M. D.

19

(Address) 2942 E. Fayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

New York 072 E. Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32010

## CERTIFICATE OF DEATH.

31 E 32010

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 18-76 WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

2-FULL NAME Eugene Keys(a) RESIDENCE NO. 1013 W. Saratoga st.  
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
 (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed,  
or Divorced, (write the word) Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1910

7 AGE Years Months Days If LESS than  
1 day, hrs. or min.  
18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Laborer(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)  
(State or country) Baltimore  
Maryland10 NAME OF FATHER Warner Keys11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown12 MAIDEN NAME OF MOTHER S. White13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Maryland14 Informant Hospital Records  
(Address)15 MAR 24 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 192817 I HEREBY CERTIFY, That I attended deceased from  
February 15, 1928 to March 22, 1928that I last saw him alive on March 22, 1928and that death occurred, on the date stated above, at 4:45 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary TuberculosisUnknown (duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)Unknown (duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? clinical + autopsy(Signed) J. M. Madden, M. D.3-22-28 (Address) Baltimore City Hospitals\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL DATE OF BURIALMount Airy 3/24/28  
UNDERTAKER ADDRESS Or all

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

E 32011

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32011

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 St. Hoffman ST. 17-24 WARD)

## 2-FULL NAME

Celia Hillis

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

502 St. Hoffman ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Widowed

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Edward Hillis

6 DATE OF BIRTH (month, day, and year) — — 1890

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

58

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Charles Co. Md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Bertie Taylor 502 St. Hoffman St.

15

FILE

R 24 1928 G. MARCH 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from

4+87 1928 to March 22, 1928,

that I last saw her alive on March 22, 1928,

and that death occurred, on the date stated above, at 1:12 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral thrombosis

(duration) yrs. mos. 71 ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis

(duration) yrs. 3-mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Lee Ellis, M. D.

3/23, 1928 (Address) 924 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Vernon Cemetery 3/24 1928

UNDERTAKER

ADDRESS 916

Samuel Taylor 704 Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32012

## CERTIFICATE OF DEATH.

REGISTERED NO.

32012

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 545 W Hoffman Ward 17-24)

## 2-FULL NAME

Wm Johnson

## (a) RESIDENCE NO.

545 W. Hoffman

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

Col

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

July-1927

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.8-

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

## 10 NAME OF FATHER

Wm Johnson

## 11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

## 12 MAIDEN NAME OF MOTHER

Gertrude Snyder

## 13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

## 14

Informant  
(Address)Eva Coleman  
545 W Hoffman

## 15 Filed

Wm Johnson  
John

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

(Inquest, au-

topsy or inquiry.) find that said deceased came to..... death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) .....yrs. ....mos. 6 ds.CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

F. C. Smith

M. D.

(Address)

North Ave & Union

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

In the

death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR Date of Burial

Wm Johnson3/241928

## 20 UNDERTAKER

Daniel Carter

ADDRESS

2169th

N. B.—WRITE PLAINLY. Age should be carefully supplied. AGE should be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificate. very important.

E/32013

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32013

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL)ST. 14-70 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Walter Battery(a) RESIDENCE NO. 1519 Brewster

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred Life mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-22-27

7 AGE Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md10 NAME OF FATHER Walter Army

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ruth Battery13 BIRTHPLACE OF MOTHER (city or town) (State or country) md14 Informant Records (Address)15 Filed 1928 19 \_\_\_\_\_ Registrar RRH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22-28

17

I HEREBY CERTIFY, That I attended deceased from Mar 13, 1928, to Mar 22, 1928,that I last saw him alive on Mar 22, 1928,and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia - entire right side secondary to pertussis(duration) yrs. \_\_\_\_\_ mos. 12 ds.CONTRIBUTORY Pertussis (Secondary)(duration) yrs. 3 mos. \_\_\_\_\_ ds.18 Where was disease contracted if not at place of death? At homeDid an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? None(Signed) J. C. Goodwin, M. D.3/24/28 (Address) Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OF

DATE OF BURIAL

Alt-Century Cem3/24/28

BURIAL

ADDRESS 578Funeral Home, Inc.mation should be  
CAUSE OF DEATH in plain terms, so that it may be  
TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32014

## CERTIFICATE OF DEATH.

REGISTERED NO. 32014

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1006 Madison Ave St 11-24 Ward)2-FULL NAME Ernestine Thomas(a) RESIDENCE NO. 1006 Madison Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred one yrs. 8 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Single6a If married, widowed, or divorced HUSBAND of (or) WIFE of Child6 DATE OF BIRTH (month, day, and year) July 5, 19267 AGE Years 1 Months 8 Days 17 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Harmon Thomas11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)12 MAIDEN NAME OF MOTHER Irene Spencer13 BIRTHPLACE OF MOTHER (city or town) Charleston W. Va (State or country)14 Informant Irene Thomas (Address) 1006 Madison Ave15 Date of death Mar 22 1928

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Signed) J. E. Kirk M. D.(Address) 1006 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death:

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hill Country Cem Date of burial 3/24/2820 UNDERTAKER Samuel J. Brady ADDRESS 78

Exact statement of death should be carefully supplied. AGE should be properly classified. OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

R 24 1928

E 32015

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32015

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 W. 20th

ST. 12-51 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Jack Haines

## (a) RESIDENCE NO.

109 W. 20th

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

4

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

C.

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of or WIFE of

## 6 DATE OF BIRTH (month, day, and year)

July 2, 1915

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

12

8

20

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

School Boy

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Leigh Ga

## 10 NAME OF FATHER

Anderson Haines

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ga.

## 12 MAIDEN NAME OF MOTHER

Ida Overton

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Leigh Ga.

## 14

Informant (Address)

Ida Haines 109 W. 20th St.

AR 24 1928

19

NPH

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 22 1928

## 17

I HEREBY CERTIFY, that I attended deceased from Feb 25, 1928, to Mar 22 1928

that I last saw him alive on

Mar 22, 1928

and that death occurred, on the date stated above, at

11:45th m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

P. G. Anderson

(Address)

1534 - Oak Hill

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Mount Calvary Mar 24 1928

Mrs. R. G. Elliott

E 32016

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32016

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 S Catherine ST. 20-72 WARD)2. FULL NAME Dorothea E Clark(a) RESIDENCE NO. 532 S Catherine ST. 20-72 WARD

(Usual place of abode)

Length of residence in city or town where death occurred / 8 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single6 If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) June 18997 AGE Years 18 Months 9 Days 16 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER George J Clark11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md12 MAIDEN NAME OF MOTHER Dora Hummer13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md14 Informant George J Clark (Address) 532 S Catherine St15 24 1928 C. KAMPION JONES, N. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22-28 19 2817 I HEREBY CERTIFY, That I attended deceased from 2/13/28 19 28 to 3/22/28 19 28 that I last saw him alive on 3/22/28 19 28 and that death occurred, on the date stated above, at 5:10 P m. The CAUSE OF DEATH\* was as follows:Under FatalCONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 5 (duration) (7) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. W. Jones M. D. (Address) 37 S. Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Order Hill

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Bernard E. Harlan

Information should be carefully checked in plain terms, so that it may be properly transmitted. CAUSE OF DEATH is very important. See instructions on back of certificates.

E 32017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 2864 Ward)

2-FULL NAME States Edwards

(a) RESIDENCE NO. 5600 Stonington Ave., Howard Park.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Helen M. Edwards (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1883

7 AGE 47 Years 7 Months 7 Days 8 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hamilton Brown Shoe Co.

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER States Edwards

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Emma Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. H. M. Edwards (Address) 5600 Stonington Ave.,

15 Filed 1928 AR Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 - 28 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [Signature] M. D. (Coroner)

3/24<sup>19</sup> 28 Address 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS



E 32018

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32018

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Guilford Ave ST. 12-19 WARD)2-FULL NAME George W. Fletcher(a) RESIDENCE NO. 1706 Guilford Ave  
(Usual place of abode)Length of residence in city or town where death occurred 71 yrs. 8 mos. 19 ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD \_\_\_\_\_

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced  
HUSBAND of Clara J. Fletcher  
or WIFE of6 DATE OF BIRTH (month, day, and year) July 3, 1856

7 AGE

Years 71Months 8Days 19If LESS than  
1 day, hrs. \_\_\_\_\_  
or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) City10 NAME OF FATHER W. Fletcher11 BIRTHPLACE OF FATHER (city or town) City  
(State or country)12 MAIDEN NAME OF MOTHER Priscilla J. Gallaway13 BIRTHPLACE OF MOTHER (city or town) City  
(State or country)

14

Informant Dorance Swann  
(Address) 52 Park Ave. Brooklyn

15

MAR 24 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Jan. 28, 1928, to Mar. 22, 1928,  
that I last saw him alive on March 22, 1928,  
and that death occurred, on the date stated above, at 1:10 p.m.  
The CAUSE OF DEATH\* was as follows:myocarditis(duration) 3 yrs. — mos. — ds.CONTRIBUTORY (Secondary) Arteriosclerosis(duration) 10 yrs. — mos. — ds.18 Where was disease contracted  
if not at place of death? \_\_\_\_\_Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) Gustavus C. Dohme, M. D.3/23/28 (Address) 3014 St Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Greenmount CemeteryDATE OF BURIAL Mar 25 1928UNDERTAKER W. Lickner & SonADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be put on back of certificate. See instructions on back of certificates.

32019

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32019

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 541 Oxford St., 17-24 Ward)2-FULL NAME... Baby Girl Groom(a) Residence No. 541 Oxford St., 17-24 Ward

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Black

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar 20, 1928

7-AGE,

yrs. mos. ds. 3 ds.

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town; State or Country), Baltimore Md.

## PARENTS.

10-NAME OF FATHER,

Joseph Wells11-BIRTHPLACE OF FATHER (city or town; State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER,

Alice Groom13-BIRTHPLACE OF MOTHER (city or town; State or Country), Baltimore Md.

14-

(Informant), Joseph Wells(Address), 541 Oxford St.

15-

Filed

1928

J. A. JONES

J. A. JONES

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year), Mar 23, 192817- I HEREBY CERTIFY, That I attended deceased from Mar 20, 1928, to Mar 23, 1928that I last saw her alive on Mar 23, 1928and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH\* was as follows:

Prematurity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Phys exam(Signed), Wright Reynolds, M. D., 19 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL,

mt duburn cemetery March 23, 1928

20-UNDERTAKER,

ADDRESS

John H. Radwin 127 Dismare

in plain terms, so that it may be properly understood by the public, and instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32020

## CERTIFICATE OF DEATH. X

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL*ST., *7-9* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Maria Music*(a) RESIDENCE NO. *East Point, Kentucky*  
(Usual place of abode)

ST., \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred

yrs.

mos.

*12*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Male**White**Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

Filed

*Records**MAR 24 1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 23 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*March 11, 1928*, to *March 23, 1928*.that I last saw him alive on *March 23, 1928*and that death occurred, on the date stated above, at *11:29 a.m.*

The CAUSE OF DEATH\* was as follows:

*Brain Lues - cerebellum  
Glioma (benign)*(duration) yrs. *18* mos. ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. *3* ds.18 Where was disease contracted  
if not at place of death? *Home*Did an operation precede death? *Yes* Date of *3-13-28*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical & Operative*

(Signed)

*J. S. Conner*

M. D.

3-23-1928 (Address)

*Johns Hopkins Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*East Point Ky*  
UNDERTAKER*3/24/28*

ADDRESS

*Joseph Ahrens**221 Broadway*

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

E 32021

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32021

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4805 Richards ST. 77-41 WARD)2-FULL NAME Martin E. Hagerman(a) RESIDENCE No. 4805 Richards ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Ernie E. Hagerman  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 27, 1871

7 AGE

Years 56Months 7Days 24If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.10 NAME OF FATHER Martin E. Hagerman11 BIRTHPLACE OF FATHER (city or town) (State or country) Prussia12 MAIDEN NAME OF MOTHER Berger13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14

Informant  
(Address) Ernie E. Hagerman  
4805 Richards St.

15

Filed

MAR 24 1928

C. J. JONES  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1928

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1928, to July 22, 1928,  
that I last saw him alive on July 21, 1928and that death occurred, on the date stated above, at 1:20 p. m.

The CAUSE OF DEATH\* was as follows:

Cerebral(duration) 2 yrs. 2 mos. 2 ds.CONTRIBUTORY (Secondary) Arterio sclerosis(duration) 2 yrs. 2 mos. 2 ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? No Date of ✓Was there an autopsy? NoWhat test confirmed diagnosis? Clinical methods(Signed) George E. Shannon M. D.2/2/1928 (Address) 700 Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Mount OlivetDATE OF BURIAL Aug 24, 1928

20 UNDERTAKER

ADDRESS

W. H. Hagerman, 1853 N. Balto St

CAUSE OF DEATH in plain terms, so that it can be understood by laymen. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32022

## CERTIFICATE OF DEATH.

31 E 32022

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals (T.B. 5-8 ST., 5-8 WARD)2-FULL NAME Alverta Stowers

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 411 N. Central ave.ST., Unknown WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Separated5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 19047 AGE 24 Years Months Days If LESS than 1 day, hrs. or min. 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland  
(State or country)10 NAME OF FATHER Will Brown11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records  
(Address)15 AR 24 1928 C. HAMMON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 192817 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 19 27, to March 21, 19 28.that I last saw her alive on March 21, 19 28.and that death occurred, on the date stated above, at 7.10 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis  
(duration) Unknown yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [Signature] M. D.3-21-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Oshtey Cemetery Mar. 29 192820 UNDERTAKER Mrs. R. A. Elliot ADDRESS 1725 Ashland

CAUSE OF DEATH in plain terms, so that it can be read by anyone. See instructions on back of certificates.



# E 32024 HEALTH DEPARTMENT—CITY OF BALTIMORE E 32024

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4700 Amberley Ave 28-71 WARD)

2-FULL NAME Josephine D. Cassell

(a) RESIDENCE NO. 4700 Amberley Ave  
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD \_\_\_\_\_

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 1848

7 AGE Years 79 Months 10 Days 14 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Md

10 NAME OF FATHER Charles E Anderson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eliza Franklin

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Baltimore Md

14 Informant Catherine Plitt  
(Address) 4700 Amberley Ave

15 Filed 24 1928 Registrar W. H. Jones

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21/ 1928

17 I HEREBY CERTIFY, That I attended deceased from 3/4/ 1928 to 3/21/ 1928

that I last saw him alive on 3/21/28, 19

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma uteri

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? usual

(Signed) Benjamin J. Perry M. D.

27 1928 (Address) 912 W. Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mount Olivet

March 24 1928

20 UNDERTAKER

George Smith

Hollins

Information should be carefully checked in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

MAR 24 1928

E 32025 HEALTH DEPARTMENT—CITY OF BALTIMORE E 32025

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N. Fremont Ave. ST. 11 WARD)

2. FULL NAME J. Morris Green

(a) RESIDENCE NO. 224 N. Fremont Ave. ST. 11 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 75 mos.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Green

6 DATE OF BIRTH (month, day, and year) May 16 1888

7 AGE Years 89 Months 10 Days 7 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co.

10 NAME OF FATHER George Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Catherine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mary Ellen Green (Address) 224 N. Fremont Ave.

15 Filed G. HAMMOND JOHNS, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1928

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to March 23, 1928, that I last saw him alive on March 23, 1928,

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH\* was as follows:

Sudden death (Heart)  
Myocardial infarction / Coronary artery disease  
Hypertension (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chyloplegia

(Signed) Herbert C. Jones, M. D.

Pr. 19 (Address) 3107 Melrose Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

Mar 24 1928

20 UNDERTAKER

ADDRESS 1532

George J. Smith Hollins

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

AR 24 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32026

## CERTIFICATE OF DEATH.

11-00 E 32026

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Stricker ST. 6-11 WARD)2-FULL NAME Michael Kudirka(a) RESIDENCE NO. 108 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Elizabeth Kudirka  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18697 AGE Years Months Days If LESS than 1 day, hrs. or min. 59

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania10 NAME OF FATHER John Kudirka11 BIRTHPLACE OF FATHER (State or country) Lithuania12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

## PARENTS

14 Informant (Address) Joseph Kudirka  
108 N. Stricker St.

## 15

Filed 24 1928C. KAMPHON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 19 2817 I HEREBY CERTIFY, That I attended deceased from 3/1 1928, to 3/20 1928, that I last saw him alive on 3/20 1928, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH\* was as follows:

Bright's - acuteCONTRIBUTORY (Secondary) Lagrippe (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. G. Friedman, M. D.  
3/23 1928 (Address) 918 E. Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR RE-INTERMENT OR RE-INTERMENT DATE OF BURIAL

Holy Redeemer Cemetery 3/26 1928

20 UNDERTAKER

ADDRESS

Chas. B. Kucharskas 637 N. Bay

mation should be carefully supplied. See instructions on back of certificates.

E 32027

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2716 Fleet. ST. 13 WARD)

## 2-FULL NAME

Harol. Para

## (a) RESIDENCE NO.

2716 Fleet.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Catharine Para

## 6 DATE OF BIRTH (month, day, and year)

1872

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5600

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Poland

## 10 NAME OF FATHER

Joseph Para

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant (Address)

Catharine Para

## 15

HAMMON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3-22-28

## 17

I HEREBY CERTIFY, That I attended deceased from

3-4281928192819

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

La grippe

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL CREMATION OR RE-

## DATE OF BURIAL

3/26 1928

## ADDRESS

Burial

Address

1118East

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

R 24 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32029

## CERTIFICATE OF DEATH.

90 ✓ E 32029

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3403 Cedar Place No. 2 St., 16-2 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 3403 Cedar Pl. St. 16-2 Ward(Usual place of abode) 30

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds. life

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Samuel R. King Jr.

6 DATE OF BIRTH (month, day, and year)

December 12, 18697 AGE Years Months Days IF LESS than 1 day hrs. or min.  
58 3 11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Frederick Co. Md.

## 10 NAME OF FATHER

Wm. Keggsey

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Frederick Co. Md.12 MAIDEN NAME OF MOTHER Susan Olier

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Frederick Co. Md.

## 14

Informant Mrs. Helen Keifner  
(Address) 3403 Cedar Place15 Filed 25 19289 1928 Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 192817 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry  
(Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said Inquiry and that said deceased came to her death  
(Inquest, autopsy or inquiry.)The CAUSE OF DEATH\* was as follows:  
Myocardial Stenosis

## CONTRIBUTORY (Secondary)

031 mar 24/28 143 No 3 way  
(Signed) (Coroner) (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Baltimore Cemetery3/27 19 28  
ADDRESS

## 20 UNDERTAKER

Albert L. Kelly1606 N. Chester sttion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUR-  
OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.  
very important.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32030

## CERTIFICATE OF DEATH.

90 E 32030

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2110. E. Fayette St.* ST., *18-16* WARD)2-FULL NAME *Emma Oser*(a) RESIDENCE NO. *2110. E. Fayette St.* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred *31* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *31* yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND (or) WIFE of *Jack Oser*6 DATE OF BIRTH (month, day, and year) *Jan 18 1898*

7 AGE

Years *65*Months *—*Days *—*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Anton*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Anna*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14

Informant *Miss Oser*  
(Address) *2110 E. Fayette St.*

15

MAR 25 1928  
Filed  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/25 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*1900, not interrupted to 1928*that I last saw her alive *on her death* *1928*and that death occurred, on the date stated above, at *4 9* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular Heart Disease Arteriosclerosis Hypertension Myocarditis Gradual (duration) many yrs. mos. ds.*CONTRIBUTORY (Secondary) *Acute dilatation of heart* (duration) *sudden* yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Diagnosis by Lymphatic*(Signed) *Frank D. Smith* M. D.*3/15, 1928* (Address) *927 E. Calvert St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Heaven Home Run* *3/25 1928*

UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Calvert St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32031

## CERTIFICATE OF DEATH.

E 32031

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 S Fremont Ave ST. 18-29 WARD)2-FULL NAME Baby Weinkblatt(a) RESIDENCE No. 16 S Fremont Ave ST. 18-29 WARD(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day 1 hrs.  
or 30 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
3/24, 19 28, to 3/24, 19 28that I last saw her alive on 3/24, 19 28and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH\* was as follows:

Primature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date of 3/24Was there an autopsy? NoWhat test confirmed diagnosis? Chloroform

(Signed)

(Address) 2046 Eutan

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

MAR 25 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32032

## CERTIFICATE OF DEATH.

E 32032

1-PLACE OF DEATH

University Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 3-4 WARD)

2-FULL NAME

Evelyn Haupt

(a) RESIDENCE No.

1532 Eastern Ave

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

May 7 / 1926

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

10

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

Geo. Haupt

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Emma Hartman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

Geo. Haupt  
1532 Eastern Ave

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3 / 28 1928

17

I HEREBY CERTIFY, That I attended deceased from

3 / 13 1928, to 3 / 28 1928,

that I last saw her alive on 3 / 28 1928,

and that death occurred, on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH\* was as follows:

① Broncho Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical &amp; Pathology

Signed

A. H. Juchaczewski, M. D.

1928 (Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOI

DATE OF BURIAL

Mt. Carmel

3 / 27 1928

20 UNDERTAKER

ADDRESS

J. J. Fickowski 1618 Eastern

CAUSE OF DEATH in plain terms, so that the layman can understand. See instructions on back of certificates.

MAR 20 1928





E 32034 HEALTH DEPARTMENT—CITY OF BALTIMORE E 32034

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Portland

2-FULL NAME Margaret A Link

(a) RESIDENCE No. 704 Portland

(Usual place of abode)

Length of residence in city or town where death occurred Not known

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST., WARD

(If non-resident give city or town and State)

ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of George Link

6 DATE OF BIRTH (month, day, and year)

Mar 19-1845

7 AGE

83

Years

5

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Not known

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not known

14

Informant (Address)

Walter A. Link  
704 Portland St

15

Filed

MAR 25 1928

NAMESON JOHN H. D

21-29

WARD

ST., WARD

(If non-resident give city or town and State)

ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1928

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 10-27, 19 to March 24, 1928.

that I last saw her alive on March 23, 1928,

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Allen C. Baughman M. D.

3-24, 1928 (Address) 313 95 Baltimore St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt Hope Cemetery Woodlawn

20 UNDERTAKER

Powell &amp; Albough

DATE OF BURIAL

Mar 28 1928

ADDRESS

Woodlawn

Information should be given in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32035  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

52 E 32035

CITY OF BALTIMORE: (No. Roland Ave. near Lake St. 27-53 WARD)2-FULL NAME Annie DeverREGISTERED NO. \_\_\_\_\_  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)(a) RESIDENCE NO. Roland Ave. near Lake St. 27-53 WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred 34 yrs. -- mos. -- ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 34 yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed,  
or Divorced, (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of  
-----6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years 49 Months -- Days -- If LESS than  
1 day, .... hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Nun 065  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Convent of the  
(c) Name of employer Visitation9 BIRTHPLACE (city or town)  
(State or country) Ireland10 NAME OF FATHER Michael Dever11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Ireland12 MAIDEN NAME OF MOTHER Margaret Lehan13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Ireland14 Informant Mother Placide  
(Address) Roland Avenue15 MAR 25 1928 C. 27-53 JONES, R.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 192817 I HEREBY CERTIFY, That I attended deceased from  
March 10th, 1928, to March 24th, 1928,  
that I last saw her alive on March 23rd, 1928,  
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction.  
Secondary Anaemia(duration) yrs. 5 mos. -- ds.CONTRIBUTORY Arteriosclerosis  
(Secondary)(duration) 2 yrs. -- mos. -- ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? to Date of --Was there an autopsy? noWhat test confirmed diagnosis? Hypertension(Signed) J. A. Chastard M. D.Mar 24 1928 (Address) 308 N. Calvert St.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Cathedral Cemetery3/26 1928

UNDERTAKER

ADDRESS

Henry U. Mears & Son 805 N. CalvertCAUSE OF DEATH in plain terms, so that  
TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32036

## CERTIFICATE OF DEATH.

90 E 32036

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Normandie Apts-17-50* ST. *50* WARD)2-FULL NAME *Florence McCullough Patterson*(a) RESIDENCE NO. *Normandie Apts-* ST. *50* WARD *Resident*

(Usual place of abode)

Length of residence in city or town where death occurred *67* yrs. *4* mos. *3* ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? *67* yrs. *4* mos. *3* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Thos. G. Patterson*6 DATE OF BIRTH (month, day, and year) *Nov-21-1860*

7 AGE

Years *67*Months *4*Days *3*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *none*(c) Name of employer *none*9 BIRTHPLACE (city or town) (State or country) *Balto. Md.*10 NAME OF FATHER *John G. McCullough*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Stuen de Grae Maryland*12 MAIDEN NAME OF MOTHER *Annie C. Wood*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Hamando Md.*

14

Informant (Address) *Mr. Thos. G. Patterson*  
*2624 St Paul St*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/24 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 23*, 1928, to *Mar 24*, 1928,that I last saw him alive on *Mar 24*, 1928and that death occurred, on the date stated above, at *6 a m*

The CAUSE OF DEATH\* was as follows:

*Thrombosis of Coronary artery (Angina Pectoris attack)*(duration) — yrs. — mos. *1* ds.CONTRIBUTORY (Secondary) *Chronic Endocarditis*

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *24* Date of *✓*Was there an autopsy? *24*What test confirmed diagnosis? *✓*(Signed) *Jefferson Quack*, M. D.Address *215 S. Club Rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Gravestone family - Mar 26 1928*

DATE OF BURIAL

20 UNDERTAKER *Stewart Monro*ADDRESS *Balto*

CAUSE OF DEATH IN plain terms. See instructions on back of certificate. TION is very important

MAR 25 1928

Registrar

E 32037

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32037

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 Keswick Road ST. 26 WARD 9)2-FULL NAME Alice Gertrude Vest(a) RESIDENCE NO. 418 Keswick Road ST. 26 WARD 9  
(Usual place of abode)Length of residence in city or town where death occurred 10 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 68 yrs. 4 mos. 7 ds. (If non-resident give city or town and State)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed or divorced HUSBAND of (or) WIFE of William E. Vest6 DATE OF BIRTH (month, day, and year) Nov-17-18597 AGE Years 68 Months 4 Days 7 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) Brooklyn  
(State or country) Iowa10 NAME OF FATHER Peter Woods11 BIRTHPLACE OF FATHER (city or town) Brooklyn  
(State or country) Iowa12 MAIDEN NAME OF MOTHER Ellen Nelson13 BIRTHPLACE OF MOTHER (city or town) Brooklyn  
(State or country) Iowa14 Informant Dr. C. W. Vest - (son)  
(Address) 1014 St Paul St City

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 192817 I HEREBY CERTIFY, That I attended deceased from March 1, 19 28, to March 24, 19 28, that I last saw her alive on March 23, 19 28, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis(duration) 1 yrs. ? mos. ? ds.

## CONTRIBUTORY

(Secondary) Myocarditis (duration) 5 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical Examination  
(Signed) C. W. Vest M. D., 19 (Address) 1014 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Montezuma - Iowa May 31, 1928

20 UNDERTAKER

ADDRESS

Stewart Momen Co. Balto.

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

MAR 25 1928

Registrar





E 32039

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital 13-52* ST. *13-52* WARD)2-FULL NAME *Ida Clark*(a) RESIDENCE No. *712 Roland Ave* ST. *13-52* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *Colored*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John Clark*6 DATE OF BIRTH (month, day, and year) *Jan. 1905*

7 AGE

Years *17*Months *23*Days *2*If LESS than 1 day, *0* hrs. *0* min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Nurse*(b) General nature of industry, business, or establishment in which employed (or employer) *086*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Hyannis, Mass.*10 NAME OF FATHER *John Clark*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Pa.*12 MAIDEN NAME OF MOTHER *Lizzie Williams*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Pa.*

14

Informant (Address) *Ida Clark*  
*Washington D. C.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/25/28* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *3/20/28*, 19 *28*, to *3/25/28*, 19 *28*, that I last saw her alive on *3/25/28*, 19 *28*.and that death occurred, on the date stated above, at *4:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*typhoid fever*(duration) *0* yrs. *0* mos. *0* ds.CONTRIBUTORY (Secondary) *intestinal hemorrhage*(duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Partial*What test confirmed diagnosis? *Clinical*(Signed) *A. Lawrence Fahmy*, M. D., 19 *28* (Address) *St. Joseph Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Hyattsville Pa.*DATE OF BURIAL *27* 19 *28*20 UNDERTAKER *Wm. Cook 502 E. North*

ADDRESS

CAUSE OF DEATH is very important. See instructions on back of certificate.

MAR 25 1928

*Geo. A. Loughran*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

32040

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 7-9 Ward)

## 2-FULL NAME

Geo A. #oughran(a) RESIDENCE NO. Ellicott City, Md. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 13/28

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md

10 NAME OF FATHER

Paul Loughran

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Frances H Pikey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant Father

(Address)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquir (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signature)

(Coroner)

3/25/28

(Address)

503 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

Ben Cathedral Cemetery March 28  
Geo M. StarrEllicott City

tion should be carefully supplied. OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. very important.

MAR 25 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32041

## CERTIFICATE OF DEATH.

E 32041

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 E. North Ave. 15-21

ST. (WARD)

## 2-FULL NAME Joseph J. Graham

(a) RESIDENCE NO. 1704 E. North Ave.

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

— — 1857

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

76

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Mr. Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Sarah J. Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Dr. J. A. Miller

15

Filed

MAR 25 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 11, 1928, to March 24, 1928, that I last saw him alive on March 23, 1928,

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH was as follows:

Acute Cardiac Dilatation with Pulmonary Edema

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

CONTRIBUTORY (Secondary) Insanity &amp; Starvation

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. K. Johnson M. D.

(Address) 1206 St. Paul St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

1206 St. Paul St.

3/26 1928

20 UNDERTAKER

ADDRESS

J. J. Sneyd

1318 Light St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 608 Meyers Court.

## 2-FULL NAME

James Jones-(C)

## (a) RESIDENCE NO.

608 Meyers Court.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs.

mos.

ds.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)Male.ColoredSingle.6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

April 3, 1889

## 7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

381119

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workLaborer.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Virginia.

## 10 NAME OF FATHER

James Jones.(C)

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia.

## 12 MAIDEN NAME OF MOTHER

Lillie Woods.(C)

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia.

## 14

Informant Annie Byrd.(C) sister.  
(Address) Richmond Va.

REGISTERED NO.

E 32042(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 22, 1928

## 17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry

and that said deceased came to

(Inquest, au-

topsy or inquiry.)

no death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

8/24, 1928 (Address) 1017 E. Charles St.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds.

In the

State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVALRichmond

20 UNDERTAKER

R. L. Parkman 824 Beran3/25 1928

ADDRESS

tion should be carefully supplied. See instructions on back of certificate.  
OF DEATH in plain terms, so that it may be properly classified. Exact statement of

MAR 25 1928

JAMES JONES, JR. M.D.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32043

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 32043

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

62

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Carpenter

9 BIRTHPLACE (city or town,  
State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town,  
State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town,  
State or country)

14

Informant  
(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from

Mar 8, 1928, to Mar 24, 1928

that I last saw him alive on Mar 24, 1928

and that death occurred, on the date stated above, at 12.55 P. M.

The CAUSE OF DEATH\* was as follows:

Arricular Fibrillation  
Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis T. Levy, M. D.

Address W. Baltimore General Hospital

\*State the Disease Causing Death, or in Deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Sykesville Md.

Mar 26, 1928

20 UNDERTAKER

ADDRESS

Weer &amp; Son, Inc. Sykesville Md.

CAUSE OF DEATH SECTION is very important. See instructions on back of certificate.

**E 32044**

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

**E 32044**

## 1-PLACE OF DEATH

City of BALTIMORE; (No. *11404 Junior 14-70* Ward)2-FULL NAME *Miss Annie Gertrude Kneuborn*(a) RESIDENCE NO. *2005 70adison Dr* St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *5* yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

17 I HEREBY CERTIFY, That I attended deceased from *Mar 16th 1928* to *Mar 25th 1928* that I last saw h. *alive on Mar 25th 1928* and that death occurred, on the date stated above, at *1300* m.

The CAUSE OF DEATH\* was as follows:

*Acute Toxicoinfection (diphtheria)*

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of *Mar 25th 1928*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*White Rock Cem. Mar 28 1928*

20 UNDERTAKER

ADDRESS

*Neer & Son Inc. 515 E. 12th St.*

MAR 25 1928

HAMPSON JONES, JR.

Registrar

tion should be carefully supplied. OF DEATH in plain terms, so that it may be properly classified. Exact statement on back of certificates. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32045

## CERTIFICATE OF DEATH

38 E 32045  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Morrey Hospital 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Mackin  
1101 Forrest Place(a) RESIDENCE NO. Forrest Chase St. 5 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 15 ds. How long in U. S. if of foreign birth? 3 yrs. 1 mos. 15 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed or divorced  
HUSBAND of Mary S Mackin  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept 1, 18927 AGE Years 55 Months 6 Days 24 IF LESS than 1 day 1 hrs. 02 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

## 9 BIRTHPLACE (city or town)

(State or country) Balt Md10 NAME OF FATHER Monis M Mackin11 BIRTHPLACE OF FATHER (City or town)  
(State or country) Balt Md12 MAIDEN NAME OF MOTHER Katherine Daily13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Md14 Informant Katherine T Eastwood  
(Address) 1101 Forrest Place

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/28 1917 I HEREBY CERTIFY, That I attended deceased from 3/24/28, 19, to 3/25/28, 19that I last saw him alive on 3/25/28, 19and that death occurred, on the date stated above, at 10:25 am

The CAUSE OF DEATH\* was as follows:

Lucetic Cardio-Vascular Disease(duration) unknown yrs. 0 mos. 0 ds.CONTRIBUTORY Acute Anemia  
(Secondary)(duration) unknown yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 3/25/28Was there an autopsy? yesWhat test confirmed diagnosis: Autopsy(Signed) J. E. Winkler, M. D., 19 (Address) Morrey Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Ignace, St. Ignace Rd Date of Burial 3/27/2820 UNDERTAKER St. IgnaceADDRESS 500 E. North St

MAR 26 1928

Registrar

tion should be carefully supplied. Exact statement of occupation should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32046

## CERTIFICATE OF DEATH.

31 E 32046

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 Walnut Av/, Hamilton <sup>27-43</sup> WARD)

2-FULL NAME Mrs. Flora C. Heiser

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 310 Walnut Av.

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/28 19

17

I HEREBY CERTIFY, That I attended deceased from March 1st, 1928, to March 24th, 1928.

that I last saw her alive on March 24th, 1928.

and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH\* was as follows:

Phthisis Pulmonis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susan A. Smith, M. D.

3/25, 1928 (Address) Crocker, 574d.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be placed on back of certificates. TION is very important. See instructions on back of certificates.

APR 26 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32047

## CERTIFICATE OF DEATH.

E 32047

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL*)

## 2-FULL NAME

*Allison Johns*

## (a) RESIDENCE No.

*19 E. Larrabee*

(Usual place of abode)

Length of residence in city or town where death occurred

*10*

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Apr 12, 1910*

## 7 AGE

Years

Months

Days

If LESS than 1 day... hrs. or min.

*17**11**12*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Bank Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*md.*

## 10 NAME OF FATHER

*Henry J. Johns*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore*

## 12 MAIDEN NAME OF MOTHER

*Anna Allison*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore*

## 14

Informant (Address)

*Records -*

## 15

Filed

*1928*

19

*JOHNS**ALLISON*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Mar 24, 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*March 21, 1928, to March 24, 1928.*

that I last saw him alive on

*March 24, 1928.*

and that death occurred, on the date stated above, at

*8:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Brain Tumor - Cerebellar  
Growth, benign*

(duration)

yrs.

*6*

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

*Home*

Did an operation precede death?

*No*Date of *3-24-28*

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Clinical & Operative*

(Signed)

*J. S. Oman*

M. D.

3-24-1928 (Address)

*Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Gettysburg Pa*

## DATE OF BURIAL

*3/27/28*

## 20 UNDERTAKER

*Wm. Cook*

## ADDRESS

*512 E. North Ave*

CAUSE OF DEATH IN plain language. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32048

## CERTIFICATE OF DEATH.

E 32048

## 1-PLACE OF DEATH

Presbyterian Home of Maryland  
City of BALTIMORE: (No. 822 N. Carrollton ave St. 16-23 Ward)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Jeanette Dalrymple

(a) RESIDENCE NO. 822 N. Carrollton ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? 80 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female white single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
8 4 — —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Glasgow

(State or country) Scotland

10 NAME OF FATHER John Dalrymple

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Agnes Hughes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant John R. Dalrymple  
(Address) 1046 N. Gay St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1928

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to March 24, 1928, that I last saw her alive on March 24, 1928, and that death occurred, on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral Anemia

(duration) yrs. 3 mos. 530 ds.

CONTRIBUTORY Bronchitis Bicuspidata

(duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) J. M. Lempert, M. D.

2619 28 (Address) 3409 Calverton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Baltimore Cemetery

March 26 1928

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W North ave

OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

AR 26

1928

G. E. Jones, M. D.  
Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

21-8-29  
E 32049

414 E 32049

## 1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST. 13-54 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John W. Schaefer

(a) RESIDENCE NO. 2400 Calhoun Ave. ST. \_\_\_\_\_

(Usual place of abode)

WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Mrs. J. W. Schaefer

6 DATE OF BIRTH (month, day, and year)

Dec 15 1861

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

66

3

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Photographer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Md

10 NAME OF FATHER

J. H. Schaefer

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Catharina Hilgartner

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant  
(Address)

Records 1 V

15

Filed

MAR 26 1928

J. H. Schaefer, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1928

17

HEREBY CERTIFY, that I attended deceased from  
December 6 1927, to March 23 1928.

that I last saw him alive on March 23 1928.

and that death occurred, on the date stated above, at 11:00 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach,  
(inoperable).

Undetermined (duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted  
if not at place of death? I could not say.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Exploratory laparotomy

(Signed) J. D. Coman, M. D.

19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Wood Lawn

DATE OF BURIAL

3-26-28

UNDERTAKER

ADDRESS

Mrs Chas A G Rohde 3327 Edmond Ave



E 32050

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed

or Divorced (write the year)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day  
or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

1 DATE OF DEATH (month, day, and year)

I HEREBY CERTIFY, That I attended deceased from  
3-22, 1928, to 3-23, 1928.I last saw him alive on 3-23, 1928.  
and death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH\* was as follows:

Labor pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

Where was disease contracted  
if at place of death?

Did operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis J. Redagliesca, M. D.

, 19 (Address) St. Agnes Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Cross A.C. Co

3-26-1928

20 UNDERTAKER

ADDRESS

B. Burke 115 E West St

CAUSE OF DEATH  
TION is very important  
See instructions on back of certificate

MAR 26 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32051

## CERTIFICATE OF DEATH.

32051

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore City Hospital-20* ST. *10* WARD)2-FULL NAME *John Brooks*(a) RESIDENCE NO. *851 Bloom* ST. *St* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *12* yrs. mos. ds.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Ruth Brooks* ~~WIFE~~6 DATE OF BIRTH (month, day, and year) *1897*7 AGE Years *31* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Labour*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Va.*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*14 Informant *Hospital Records* (Address)

15

MAR 26 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 22 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 22, 1928* to *March 22, 1928* that I last saw him alive on *March 22, 1928* and that death occurred, on the date stated above, at *4.00 P. m.*

The CAUSE OF DEATH\* was as follows:

*lobar pneumonia*(duration) *Unknown* yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *autopsy*(Signed) *H. E. Marshall* M. D., 19 (Address) *Baltimore City Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Mount Auburn Cem**3/26-1928*

UNDER-TAKER

ADDRESS *See list*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32052

## CERTIFICATE OF DEATH

REGISTERED NO.

101-001  
E 32052

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Gilmore St St. 15-21 and)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Noble(a) RESIDENCE NO. 1412 Gilmore St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

August 15 1897

## 7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.3029

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shirt Presser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Hazen Shirt Factory

## 9 BIRTHPLACE (city or town)

Lenora Co.

(State or country)

N.C.

## 10 NAME OF FATHER

Martin Noble

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

N.C.

## 12 MAIDEN NAME OF MOTHER

Esther Noble

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Lenora Co. N.C.

## 14

Informant  
(Address)Lenora Noble  
1412 Gilmore St

## 15 Filed

W. J. JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24-1928

17

I HEREBY CERTIFY, That I attended deceased from

3-19-1928, to 3-24-1928,that I last saw her alive on 3-23-1928,and that death occurred, on the date stated above, at 5:10 A.M.

The CAUSE OF DEATH\* was as follows:

Double lobar pneumonia

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

unknown (duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death? At place of deathDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Examination(Signed) Frank A. Saunders, M. D.3-24-1928 (Address) 1029 N. Stricker St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

W. J. Jones3-26-1928

## 20 UNDERTAKER

ADDRESS 9166th andtion known to the cause of death, so that it may be properly classified.  
OF DEATH in plain terms, so that it may be properly classified.  
very important. See instructions on back of certificates.

AR 26 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32053

## CERTIFICATE OF DEATH.

E 32053

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 S Broadway ST. 4 WARD)2-FULL NAME Joseph Kresina(a) RESIDENCE NO. 238 S Broadway ST. 4 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 - 27

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

109

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Thomas Kresina11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore12 MAIDEN NAME OF MOTHER Subek13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14

Informant (Address) Mary Kresina  
238 S Broadway

15

Filed

19

P.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1928

17

I HEREBY CERTIFY That I attended deceased from Mar 24, 1928, to Mar 28, 1928.that I last saw him alive on Mar 24, 1928, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia  
following Measles  
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Ryan

19

(Address) 807 N. Kenner

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Holy Rosary March 26 1928  
W. Gazeuski 1928  
Baltimore

AR 20 1928



Letter in file from Dr B. R. Friedman dated  
HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 3-29-28

32054

## CERTIFICATE OF DEATH.

31

E 32054

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* 6-10 WARD)2-FULL NAME *Peter Zakarko*(a) RESIDENCE NO. *442 N. Suzanne Ave.* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Anna Margaret Zakarko*6 DATE OF BIRTH (month, day, and year) *December 1952*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Coat Presser*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Poland*10 NAME OF FATHER *John Zakarko*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Poland*

14

Informant (Address) *M. Zakarko 442 N. Suzanne Ave.*

15

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/24/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *3/23/28*, 19 to *3/24/28*, 19 that I last saw him alive on *3/24/28*, 19 and that death occurred, on the date stated above, at *10:50 A.M.*

The CAUSE OF DEATH\* was as follows

*pulmonary tuberculosis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Lawrence Fahren* M. D., 19 (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

ADDRESS

*Holy Rosary March 27 1928*  
*FW Ozazewski 1930*

TION is very important. See instructions on back.

MAR 26 1928

E 32055

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 432 E 21<sup>st</sup> St. 17-50 Ward)

2-FULL NAME George Joseph Binstead

(a) RESIDENCE NO. 432 E 21<sup>st</sup> St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of X (or) WIFE of Margaret Binstead

6 DATE OF BIRTH (month, day, and year)

March 4 1961

7 AGE Years 67 Months — Days 18 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst. Prop. of United Galaxy (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Ireland

10 NAME OF FATHER George Binstead

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Marie Gertrude Binstead (Address) 432 E 21<sup>st</sup> St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

I HEREBY CERTIFY, That I attended deceased from March 23 1928

that I last saw him alive on March 23 1928

and that death occurred, on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH\* was as follows:

Chr. Myocarditis (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) 90 pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. H. M. D.

19 28 (Address) 1627 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Catholic Cemetery March 26 1928

20 UNDERTAKER Mary W. Wadfield 501 E 22<sup>nd</sup> St.

OF DEATH in plain terms, so that it may be read by all. See instructions on back of certificates.

MAR 28 1928

J. J. Jones, M. D. Registrar

32056

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32056

1-PLACE OF DEATH *St. Agnes Hospital*CITY OF BALTIMORE: (No. *70-70* ST. *70* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John M. Beck*(a) RESIDENCE NO. *3443 Edmondson Ave*

(Usual place of abode)

ST. *70* WARDLength of residence in city or town where death occurred *42* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Elizabeth Beck*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

*59**8 13*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Baker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*not given*

9 BIRTHPLACE (city or town) (State or country)

*Germany*

10 NAME OF FATHER

*John Beck*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*J.C. Giese - son-in-law 512 Edmondson Ave*

15

Filed

*ST. AGNES HOSPITAL, N. M.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-23**1928*

17

HEREBY CERTIFY, That I attended deceased from

*March 23, 1928, to March 23, 1928, 7:10 P.M.*that I last saw him alive on *March 23, 1928*and that death occurred, on the date stated above, at *710 P.M.*

The CAUSE OF DEATH\* was as follows:

*Senile heart from arteriosclerosis.*

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (secondary)

*Not known*

(duration) — yrs. — mos. — ds.

Where was disease contracted if not at place of death? *3443 Edmondson Ave*Did an operation precede death? *No* Date of —

Was there an autopsy?

What was the confirmed diagnosis? *Chronic syphilitic atherosclerosis*(Signed) *W. Hoffmann* M. D.2-19-28 (Address) *8 East Read St.*

State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park**Mar 26, 1928*

20 UNDERTAKER

ADDRESS

*Miss Mrs. John H. Timpf & Son 801 W. Fayette*

TION is very important See instructions on back of card

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32057

## CERTIFICATE OF DEATH

24 ✓  
E 32057  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Sydenham Hospital 9-46* St., *3rd* Ward)2-FULL NAME *Robert L. Crowther*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2529 Aisquith St.* St. *3rd* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 13, 1925*7 AGE Years *3* Months *0* Days *12* IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *md*10 NAME OF FATHER *Robert L. Crowther*11 BIRTHPLACE OF FATHER (City or town) *W. Va* (State or country)12 MAIDEN NAME OF MOTHER *Kathryn Wood*13 BIRTHPLACE OF MOTHER (city or town) *Va* (State or country)14 Informant *Robert L. Crowther Jr* (Address) *2529 Aisquith St.*15 Filed *1925* 16 *JOHN JONES, R. E.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 25, 1928*17 I HEREBY CERTIFY, That I attended deceased from *March 23, 1928*, to *March 25, 1928*, that I last saw him alive on *March 25, 1928*, and that death occurred, on the data stated above, at *8:15 a. m.*

The CAUSE OF DEATH\* was as follows:

*Meningococcal Meningitis*(duration) yrs. mos. *6* ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? *Home*Did an operation precede death? *NO* Date ofWas there an autopsy? *NO*What test confirmed diagnosis? *Lumbar puncture* (Signed) *Myron B. Jace*, M. D.*3/25/28* (Address) *Sydenham Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Parkwood*

Date of Burial

*Mar 27, 1928*

20 UNDERTAKER

ADDRESS

*Mr. Mrs. John W. Teufel & Son* *801 W. Fayette*

tion should be made in plain terms, so that it may be properly understood. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32058

## CERTIFICATE OF DEATH.

90 E 32058

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307-W-Lanvale ST. 11-24 WARD)

## 2-FULL NAME

Richard David Maynard

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

(Usual place of abode) 307-W-Lanvale ST., Resident WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

70 yrs. ? mos. ? ds.How long in U. S., if of foreign birth? 86 yrs. 7 mos. 24 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary S. Maynard6 DATE OF BIRTH (month, day, and year) July-31-18417 AGE Years 86 Months 7 Days 24 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(h) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Albion Illinois

## 10 NAME OF FATHER

Ewen Maynard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Easton Maryland

## 12 MAIDEN NAME OF MOTHER

Louisa Eastman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Winfred Maine

## 14

Informant (Address)

Miss Mary S. Maynard/day  
307-W-Lanvale St

## 15

Filed

1928 Mar 26 1928 Regist

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8, 25, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from Feb 27, 1928, to Mar 25, 1928, that I last saw him alive on Mar 24, 1928and that death occurred, on the date stated above, at 12.30 A. M.

The CAUSE OF DEATH\* was as follows:

Parvular Dis. of HeartCONTRIBUTORY (Secondary) Old age (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. D. Whitcomb M. D.

19 (Address)

211 W. Lanvale St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Thomas' Garrison Front3/27/28  
Stewart Mowen Co Balto.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32059

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

E 32059

CITY OF BALTIMORE: (No. 4-30 WARD)

2-FULL NAME

Beatrice Grimes

(a) RESIDENCE NO.

Saxville Md.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

10

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female  
white

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

1 infant

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

December 1926

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

1

53

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

1 infant

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Saxville Md.

10 NAME OF FATHER

Jesse Grimes

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Jeanne Grimes

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

14

Informant  
(Address)Jesse Grimes  
Saxville, Md.

15

Filed

1928

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/25/28

17

I HEREBY CERTIFY, That I attended deceased from  
3/19, 1928, to 3/25, 1928.

that I last saw him alive on 3/21, 1928,

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH\* was as follows:

① Bronche Pneumonia  
② Septicemia

2.19

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical &amp; laboratory

(Signed) A. H. Lubelsteyn, M. D.

, 19 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Morton Chapel Cemetery

Mar. 27, 1928

20 UNDERTAKER

ADDRESS

C. M. Hutz, Springfield, Md.

TION is very important. See instructions.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32060

## CERTIFICATE OF DEATH.

E 32060

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 N. Larnvale ST. 16-22 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1524 N. Larnvale ST.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs.

mos.

da.

How long in U. S., if of foreign birth? yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

M

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Frank Canady

6 DATE OF BIRTH (month, day, and year)

Apr 9 - 1879

7 AGE

Years

Months

Days

48

11

14

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

North Carolina

10 NAME OF FATHER

Fennell Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Amy Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.C.

14

Informant (Address)

Rev. P. J. Jordan 1524 N. Larnvale

MAR 26 1928

File

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 23 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 22, 1928, to Mar 23, 1928, that I last saw her alive on Mar 23, 1928,

and that death occurred, on the date stated above, at 6 P. M. The CAUSE OF DEATH\* was as follows:

Abscess of Brain

CONTRIBUTORY (Secondary) Infection (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Rupture of Abscess

(Signed) J. H. Woloshyn M. D.

3/24/28 (Address) 7103 W. Lafayette

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

711 Zen

DATE OF BURIAL

Nov 26 1928

20 UNDERTAKER

J. H. Woloshyn

ADDRESS

7103 W. Lafayette

CAUSE OF DEATH printed in plain language on back of certificates. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32061

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1030 Carlton*)ST. *16-23* WARD)2-FULL NAME *Alice Brown*(a) RESIDENCE NO. *1030**1030 Carlton*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

/ yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Col*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Apr 1 - 1924*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*3**11**24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Chesterton*

10 NAME OF FATHER

*Benjamin Brown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ind*

12 MAIDEN NAME OF MOTHER

*Annals Brown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ind*

14

Informant (Address)

*Benjamin Brown  
1030 Carlton*

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 25 1928*

17

I HEREBY CERTIFY That I attended deceased from

*Mar-18-1928, to Mar-24-1928,*that I last saw him alive on *Mar-23-1928,*and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH\* was as follows:

*Acute Bronchitis  
(not Tubercular)*(duration) yrs. mos. ds. *8*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *W. T. Coleman* M. D.Address *2039 Mc Culloch*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Auburn**March 26 1928*

20 UNDERTAKER

ADDRESS

*Sam'l H. Chase Son**1400 Market*

TION is very important. See instructions on back of certificate.

AR 26 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32062

## CERTIFICATE OF DEATH.

90 E 32062

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 815 Whatcoat St., 16-22 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 815 Whatcoat St., \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of Susie Hopkins6 DATE OF BIRTH (month, day, and year) Oct 17 18827 AGE Years 45 Months 5 Days 11 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind.  
(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Ind.  
(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country)14 Informant Susie Hopkins  
(Address) 815 Whatcoat

15 Filed \_\_\_\_\_ 19 \_\_\_\_\_ Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said \_\_\_\_\_  
(Inquest, au-  
topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis  
(duration) \_\_\_\_\_ yrs. 3 mos. \_\_\_\_\_ ds.CONTRIBUTORY  
(Secondary)(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. B. Lusk M. D.  
(Coroner)19 (Address) 1014 N. 1st St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Francis Mar 23 1928

## 20 UNDERTAKER ADDRESS

Wm. H. Chace

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32063

## CERTIFICATE OF DEATH.

E 32063  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3909 Falls Road St. 13-52 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

3909 Falls Road

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 3 mos. 2 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofChild

## 6 DATE OF BIRTH (month, day, and year)

December 22/1927

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.32

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workChild(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Balto Md.

## 10 NAME OF FATHER

Joseph W Veit

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto Md.

## 12 MAIDEN NAME OF MOTHER

Anna E. Harden

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto Md.

## 14

Informant  
(Address)Joseph W. Veit  
3909 Falls Road

## 15 Filed

26 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest, au-  
topsy or inquiry.) And that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH was as follows:

Heart Disease

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

M. D.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Not Pleasant Am. Cemetery Md March 1928

## 20 UNDERTAKER

ADDRESS

Harry H. Ammons 4204 Ridgewood AveOF DEATH in plain terms, so that it may be understood by all.  
very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32064

## CERTIFICATE OF DEATH.

57 E 32064

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Clamont Ave. 16-67)

## 2. FULL NAME

(a) RESIDENCE NO. 1630 Clamont Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. 11 mos. 21 ds.

(If non-resident give city or town and State) WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced, (write the word)

Male White Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased for several years to Mar. 24, 1928, that I last saw him alive on Mar. 24, 1928,

and that death occurred, on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH\* was as follows: Chronic Bright's disease, diabetes mellitus, Arteriosclerosis.

The diabetes had existed about 15 months, the other several yrs.

CONTRIBUTORY An attack of cerebral hemorrhage 3 or 4 yrs. ago.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Nothing special

(Signed) J. V. Hoffman, M. D.

3/25, 1928 (Address) 2500 Garrison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 26 1928

Registrar

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 32065**

## CERTIFICATE OF DEATH.

172  
**E 32065**  
REGISTERED NO.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 5-9 Ward)

2-FULL NAME Geo Quinn

(a) RESIDENCE NO. 507 B Eden

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race col. 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of widow

6 DATE OF BIRTH (month, day, and year) Aug 9, 1880

7 AGE 47 Years Months 7 Days 13 IF LESS than 1 day.....hrs. or.....min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 9 BIRTHPLACE (city or town)

(State or country)

### 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

### 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

### 14

Informant Mrs Carrie Jones  
(Address) 507 Eden St.

15 Filed 1928 19

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Murder  
Jump from Window

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 4  
(Signed) J. C. Gladis M. D.  
(Address) 143 W 1st St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Ashbury Ave. Date of Burial Aug 25 1928  
20 UNDERTAKER Mrs J. G. Lock ADDRESS 1302 Jefferson

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32066

## CERTIFICATE OF DEATH.

E 32066

## 1-PLACE OF DEATH

CITY OF BALTIMORE, MD.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

26 yrs.

mos.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Apr 13 - 1901

7 AGE

26

Years

Months

5

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Harry Creagh

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Ann L. Friedrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Harry L. Creagh 207 S 7th St

15

MAR 26 1928

J. J. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/24 1928

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Generalized Peritonitis

Appended

CONTRIBUTORY (Secondary)

Pneumonia

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/19/28

Was there an autopsy? Yes

What test confirmed diagnosis? Gen. ex. &amp; autopsy

(Signed) R. L. Humphreys, M. D.

3/29 1928 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Cath. Burial

John W. Smith

DATE OF BURIAL

Mar 27 1928

ADDRESS

2808 Orleans

**E 32067**

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**E 32067**

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *9-17* WARD)2-FULL NAME *Lena Friedel*(a) RESIDENCE No. *Stemmer Run* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. *10* mos. *10* ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? *37* yrs. *—* mos. *—* ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *7*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *George Friedel*6 DATE OF BIRTH (month, day, and year) *Sept 16 1873*

7 AGE

Years *54*Months *6*Days *8*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *at Home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Peter Krause*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Margt. Brandel*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *George F. Friedel*  
*Stemmer Run & Morris Lane*

15

MAR 26 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-24-28*

17

I HEREBY CERTIFY, That I attended deceased from *March 14*, 19*28*, to *March 24*, 19*28*.that I last saw her alive on *March 24*, 19*28*.and that death occurred, on the date stated above, at *3:45 A.M.*

The CAUSE OF DEATH\* was as follows:

*Brain abscess*  
*(Left Temporal Pole)*(duration) yrs. mos. *14* ds.CONTRIBUTORY (Secondary) *Toxemia*(duration) yrs. mos. *10* ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *Yes* Date of *3/22/28*Was there an autopsy? *Yes*What test confirmed diagnosis? *autopsy*(Signed) *H. Lawrence Fehmy*, M. D., 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Sacred Heart Cemetery**Mar 27 1928*

20 UNDERTAKER

ADDRESS

*Lilly Green Inc**4008 W. 11*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 32068**

## CERTIFICATE OF DEATH.

**E 32068**

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2642 Bernard St. 12-51 WARD)

### 2-FULL NAME

Ann P. Weaver

### (a) RESIDENCE No.

2642 Bernard St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

Female

#### 4 COLOR OR RACE

White

#### 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

#### 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jacob Weaver

#### 6 DATE OF BIRTH (month, day, and year)

Dec 29 1852

#### 7 AGE

Years

Months

Days

If LESS than 1 day, 24 hrs. or 23 min.

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

md.

#### 10 NAME OF FATHER

Abraham Shinsky

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

md.

#### 12 MAIDEN NAME OF MOTHER

Sarah Chough

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md.

#### 14

Informant (Address)

Thomas Smith  
2642 Bernard St.

#### 15

Filed

**MAR 26 1928** **NATHAN JONES, N.**

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

March 23 1928

#### 17

HEREBY CERTIFY, That I attended deceased from Mar 16 1928 to Mar 23 1928

that I last saw h alive on Mar 28 1928

and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH\* was as follows:

Paralysis

#### CONTRIBUTORY (Secondary)

Cerebral Hemorrhage

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Mar 28 1928 Address

117 W. 20th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

#### DATE OF BURIAL

St. Martin Cemetery

Mar 23 1928

#### UNDER TAKER

#### ADDRESS

Chenoweth & Son

100 Chestnut St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32069

E 32069

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *161-001*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *206*St. *Chesnut* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*male white infant*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Mar 24 1928*

7 AGE

Years

Months

Days

IF LESS than 1 day 2 hrs. or 20 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filed

16

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 24 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*2/24/28* 19 to *2/24/28* 19that I last saw him alive on *2/24/28* at *11:00 a.m.*and that death occurred, on the date stated above, at *11:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Permaternity & ashenia*

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS



E 32070

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 32070

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals)

2-FULL NAME Fred James

(a) RESIDENCE NO. 1209 Myrtle ave.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER Charles James

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER H. Pinkney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Hospital Records

15

MAR 26 1928. Samuel H. Jones, Jr. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1928 to March 21, 1928

that I last saw him alive on March 21, 1928

and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Clinical & Autopsy

(Signed)

L. E. Madden, M. D.

3-22-28 Address Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOV.

DATE OF BURIAL

Samuel H. Jones, Jr.

UNDERTAKER

3/26/28

ADDRESS

Samuel H. Jones, Jr. 1400 Market

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32071

## CERTIFICATE OF DEATH

E 32071

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3310 Colgate

St. 26 Ward

2-FULL NAME *Henry A. Theis*

(a) RESIDENCE NO. 3310 Colgate

St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 9 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*June 15<sup>th</sup> 1914*

7 AGE

Year

Months

Days

IF LESS than 1 day... hrs. or min..

*3**9**9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

*Balto. Md.*

(State or country)

10 NAME OF FATHER

*William P. Theis*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Balto. Md.*

12 MAIDEN NAME OF MOTHER

*Julia R. Kubik*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto. Md.*

14

Informant (Address)

*William P. Theis Father 3310 Colgate St.*

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Wells Lawn Cemetery*

20 UNDERTAKER

*Lilly & Zuber Inc.*

Date of Burial

*Mar 27 1928*

ADDRESS

*4008 W. 10th St.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 24 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar 21*, 1928, to *Mar 24*, 1928, that I last saw him alive on *Mar 24*, 1928, and that death occurred, on the date stated above, at *9 P.M.*

The CAUSE OF DEATH\* was as follows:

*3 Bronch. Pneumonia*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Dr. J. P. Barry* M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificates.

MAR 26 1928

Def

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32072

## CERTIFICATE OF DEATH

E 32072

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *8 S. Curley* St., *112* Ward)2-FULL NAME *Dorotica Eva Smearman*(a) RESIDENCE NO. *8 S. Curley* St. *1* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *2* mos. *22* da.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 3<sup>rd</sup> 1921*7 AGE Years *1 year* Months *2* Days *22* IF LESS than 1 day...hra. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.* (State or country)10 NAME OF FATHER *Adam W. Smearman*11 BIRTHPLACE OF FATHER (City or town) *Balto. Md.* (State or country)12 MAIDEN NAME OF MOTHER *Dora E. Menken*13 BIRTHPLACE OF MOTHER (city or town) *Balto. Md.* (State or country)14 Informant *Adam W. Smearman* (Address) *8 S. Curley St.*15 Filed *1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 25 1928*17 I HEREBY CERTIFY That I attended deceased from *Mar 23 1928* to *Mar 25 1928*that I last saw *her* alive on *Mar 24 1928*and that death occurred, on the date stated above, at *8:30 a. m.*

The CAUSE OF DEATH was as follows:

*(Pneumonia Measles)**Cap. Bronchitis*

(duration) yrs. mos. da.

CONTRIBUTORY *Chaustrum*

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *Yes*What was confirmed diagnosis? *Chaustrum*(Signed) *Thy Chaustrum* M. D.(Address) *14376 Bmny*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Sacred Heart Cemetery Mar 27 1928*

20 UNDERTAKER

*Lilly - Jelen Inc.* ADDRESS *4008 S. Wey*

OF DEATH in plain terms, so that it may be read very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32073

## CERTIFICATE OF DEATH

31

E 32073

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 13284 Carey St Ward 15-23)2-FULL NAME Laurence J. Valentine(a) RESIDENCE NO. 13284 Carey St. Ward 15-23

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male colored Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Mar 1908

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

School Boy9 BIRTHPLACE (city or town) City

(State or country)

10 NAME OF FATHER L. J. Valentine

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Theresa Singh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)Singh, Valentine  
13284 Carey St.

15 Filed

1928

15-23-28

15-23-28

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23-1928March 23rd 1928

17

I HEREBY CERTIFY, That I attended deceased from October 20, 1927, to March 23rd, 1928.that I last saw him alive on March 23rd, 1928.and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary TuberculosisFrom personal knowledge

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? at place of deathDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical findings(Signed) Bernell F. L. M. D., 19 (Address) 2937 N. Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Wm. A. ...  
Bernell F. L. M. D.

OF DEATH in plain terms, so that it may be understood by all. See instructions on back of certificates. very important.

MAR 26 1928



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32074

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *University Hospital* *10-27* WARD)

2-FULL NAME *Charles Speed*

(a) RESIDENCE NO. *539 Kirby Lane*

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? *15* yrs.

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*

4 COLOR OR RACE *Caucasian*

5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Married*

6 DATE OF BIRTH (month, day, and year) *March 20 1895*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*33*

*0*

*2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Doctor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Kington, West Virginia*

10 NAME OF FATHER *not known*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *not known*

12 MAIDEN NAME OF MOTHER *not known*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *not known*

14

Informant (Address) *Samuel Speed*

15

Filed

*1928*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/22 1928*

17

I HEREBY CERTIFY, That I attended deceased from *3/15/28*, 19, to *3/22/28*, 19,

that I last saw him alive on *3/22/28*, 19,

and that death occurred, on the date stated above, at *10:40 P.M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

(duration)

yrs.

mos.

*6* ds.

CONTRIBUTORY (Secondary) *Sepsis*

(duration)

yrs.

mos.

*6* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis? *Autopsy & Laboratory findings*

(Signed) *Lewis Clark Taylor*

M. D.

, 19

(Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Mount Zion*

DATE OF BURIAL

20 UNDERTAKER *Adelich*

ADDRESS

*409 N Mount*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32075

## CERTIFICATE OF DEATH.

E 32075

1-PLACE OF DEATH

Sinai Hospital

CITY OF BALTIMORE: (No.

ST. 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Beckie Levin

(a) RESIDENCE NO.

1117 E. Pratt

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

18 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Shida Levin

6 DATE OF BIRTH (month, day, and year)

March 20, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

68

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

Jack Levin

Filed

MAR 25 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 26, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1928, to March 26, 1928.

that I last saw him alive on

March 26, 1928

and that death occurred, on the date stated above, at

7 A. M.

The CAUSE OF DEATH\* was as follows:

Respiratory Failure

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Bilateral Broncho-

pneumonia (duration)

yrs. mos. 6 ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Signs

(Signed)

J. A. Asbury

M. D.

, 19 (Address)

Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Inst Rd

3/26 1928

20 UNDERTAKER

ADDRESS

Jack Levin 1117 E Pratt St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32076

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2601 Rosewood ave. 5-58 WARD

## 2-FULL NAME

Joseph Cinguegrami

(a) RESIDENCE NO.

2601 Rosewood ave.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

15 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Vincenza Cinguegrami

6 DATE OF BIRTH (month, day, and year)

June 3, 1854

7 AGE

73.

Years

Months

9

Days

22.

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Shoe maker

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

self

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Italy

10 NAME OF FATHER

Salvatore Cinguegrami

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Italy

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Italy

14

Informant  
(Address)Habucent Cinguegrami  
206 E. 1st ave.

15

Filed

19

C. C. Kill  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1928

17

I HEREBY CERTIFY, That I attended deceased from  
March 25, 1928, to March 25, 1928,  
that I last saw him live on March 24, 1928,  
and that death occurred, on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH\* was as follows:

Bronchial - Asthma -  
Bronchial Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY Pulmonary Edema  
(Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Signed J. S. Winterhousel, M. D.  
1928 (Address) 1901 E. 1st ave. R4\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

new Cathedral Cemo

3/27 1928

UNDERTAKER

ADDRESS

Geo J Ruth 1736. Harford

E 32077

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1946 ST. 20-27 WARD)

### 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar 8, 1928, to Mar 24, 1928,

that I last saw him alive on Mar 24, 1928,

and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James B. Spence, M. D. 1928 (Address) 735 N. Fulton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

UNDERTAKER

ADDRESS

Braston, Md. 3/27 1928 James B. Spence, Md.



32078

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *723 S. Third* St., *No 37* Ward)2-FULL NAME *Emestine Martin*(a) Residence No. *723 S. Third* St., *26* Ward.

(Usual place of abode)

Length of residence in city or town where death occurred *80* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *65* yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registered No. *129 E 32078*

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Female*

4-COLOR OR RACE,

*White*5-Single, Married, Widowed, or Divorced, (Write the word.) *Widowed*

5a-If married, widowed, or divorced

HUSBAND of (or) WIFE of *late Herman Martin*6-DATE OF BIRTH (month, day and year) *Dec. 17<sup>th</sup> 1839*

7-AGE.

*88* yrs. *3* mos. *6* ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town), (State or Country), *Germany*10-NAME OF FATHER, *KAHE*11-BIRTHPLACE OF FATHER (city or town), (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Not Known*13-BIRTHPLACE OF MOTHER (city or town), (State or Country), *Germany*

14-

(Informant) *Annie Sandebich Wright*  
(Address) *723 S. Third St.*

15-

Filed *1928*Registrar, *R. H. Jones*

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *3/23/28*17- I HEREBY CERTIFY, That I attended deceased from *3/21* 19*28* to *3/23* 19*28*.that I last saw him alive on *3/20* 19*28*.and that death occurred, on the date stated above, at *3:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Arteriosclerosis**Myocarditis**Chronic interstitial nephritis**Bronchectasis*(Duration) *2* yrs. *2* mos. *2* ds.CONTRIBUTORY (Secondary) *Pulmonary edema*(Duration) *2* yrs. *2* mos. *2* ds.

18-Where was disease contracted

If not at place of death? *no*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *See Report*  
(Signed) *J. H. Jones* M. D.1928 Address *633 S. 3rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, *Mount Carmel Cemetery*DATE OF BURIAL, *March 27, 1928*20-UNDERTAKER, *Lilly & Zeiler Inc.*ADDRESS *403 S. 40th St.*

Instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32079

## CERTIFICATE OF DEATH

REGISTERED 32079

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2213 Gough St., V3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Cincotta(a) RESIDENCE NO. 2213 Gough St. 1 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S. if of foreign birth 48 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

6a If married, widowed, or divorced,

HUSBAND of  
(or) WIFE ofJennie Cincotta

6 DATE OF BIRTH (month, day, and year)

Oct. 12, 1860

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.68513

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Italy

(State or country)

10 NAME OF FATHER

Salvator Cincotta

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Italy

12 MAIDEN NAME OF MOTHER

Maria Castagna

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Italy

14

Informant  
(Address)Jennie Cincotta, Wife  
2213 Gough St.

15 Filed

MAR 26 1928

F. J. [unclear] Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 25, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 29, 1928, to March 25, 1928that I last saw him alive on March 24, 1928and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Data of ✓Was there an autopsy? NoWhat test confirmed diagnosis? Physical signs

(Signed)

Geo. H. Keller, M. D.

376, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer CemeteryMarch 28, 1928

20 UNDERTAKER

ADDRESS

Lilly Zuercher1035 W. 10th St.

OF DEATH in plain terms, so that the family may understand. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32080

## CERTIFICATE OF DEATH.

E 32080

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *123 S. Ellwood Ave* ST. *17* WARD)2-FULL NAME *Anthony Ciampaglia*(a) RESIDENCE No. *123 S. Ellwood Ave* ST. *1* WARD

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 8<sup>th</sup> 1909*

7 AGE

Years

Months

Days

*19*

If LESS than 1 day, hrs. or min.

*4 15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Tin Dero Co*

(c) Name of employer

*Tin Dero Co*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Vincent Ciampaglia*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Italy*

12 MAIDEN NAME OF MOTHER

*Concetta Monica*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Italy*

14

Informant (Address)

*Mary Ciampaglia 123 S. Ellwood Ave*

15

Filing date

*March 26 1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 23<sup>rd</sup> 1928*

17

I HEREBY CERTIFY That I attended deceased from *March 15* 1928 to *March 23* 1928.that I last saw him live on *March 23* 1928.and that death occurred, on the date stated above, at *8.20 p.m.*

The CAUSE OF DEATH\* was as follows:

*leber. pneumonia.*(duration) yrs. mos. *8* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*Chas. Lesta* M. D. *3-25-28* Address *756 W. Fayette St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Holy Redeemer*

DATE OF BURIAL

*March 24<sup>th</sup>* 1928

20 UNDERTAKER

*Frank V. Pipitone*

ADDRESS

*2818 E. Balt St*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32081

## CERTIFICATE OF DEATH.

57 E 32081

1-PLACE OF DEATH *Baltimore City Hospital* REGISTERED NO. *57 E 32081*  
 CITY OF BALTIMORE: (No. *25* ST. *Van Luven* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 2-FULL NAME *Annie Van Luven*  
 (a) RESIDENCE NO. *1213 S Charles St.* WARD  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*  
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Joseph Van Luven*  
 6 DATE OF BIRTH (month, day, and year) *Aug 16 1857*  
 7 AGE Years *70* Months *7* Days *7* If LESS than 1 day, hrs. or min.  
 8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Washington, D. C.*  
 10 NAME OF FATHER *Wm. M. M. M. M.*  
 11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*  
 12 MAIDEN NAME OF MOTHER *Annie Blum*  
 13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant *Mattie Gove*  
 (Address) *106 S. Montgomery St.*

15 Filed *Aug 26 1928* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/23 1928*  
 17 I HEREBY CERTIFY, That I attended deceased from *3/10*, 19 *28*, to *3/23*, 19 *28*, that I last saw him alive on *3/23*, 19 *28*, and that death occurred, on the date stated above, at *3* m.  
 The CAUSE OF DEATH\* was as follows:  
*Heart failure, Myocarditis, Hypertension, Atherosclerosis, Coronary artery disease, etc.*  
 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Brunch pneumonia* (duration) yrs. mos. ds. 2  
 18 Where was disease contracted if not at place of death? *Home*  
 Did an operation precede death? *No* Date of  
 Was there an autopsy? *No*  
 What test confirmed diagnosis? *Chest X-ray*  
 (Signed) *W. W. G. G.* M. D.  
 , 19 (Address) *Baltimore City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE-MOVAL *Cedar Hill Cemetery* DATE OF BURIAL *Mar 26 1928*  
 20 UNDERTAKER *Schuman Son* ADDRESS *1034*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32082

32082

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3012 Grayson St. 16-67)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Virginia Chambly

(a) RESIDENCE. No. 3012 Grayson.

(Usual place of abode)

ST. WARD.

Length of residence in city or town where death occurred 38 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs mos ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) Married
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Chambly		
6 DATE OF BIRTH (month, day, and year) Sept 9, 1889		
7 AGE 38	Years 60	Months 150
If LESS than 1 day, hrs. or min.		

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer  
none9 BIRTHPLACE (city or town)  
(State or country)  
Baltimore Md10 NAME OF FATHER  
Thos N Clift11 BIRTHPLACE OF FATHER (city or town)  
(State or country)  
Md12 MAIDEN NAME OF MOTHER  
Alice Bush13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)  
Md14 Informant  
(Address)  
Mrs. C. Chambly  
3012 Grayson St.

MAR 26 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1928.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1927, to March 24, 1928, that I last saw her alive on March 24, 1928, and that death occurred, on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Myelitis (transverse)

CONTRIBUTORY  
(Secondary)

(duration) 0 yrs. 4 mos. 9 ds.

Broncho-pneumonia

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Examination

(Signed) Chas. S. Keenstock, M.D.

19 (Address) 1730 Linden Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

J. F. McCully

March 24 1928

128 E. Fort Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32083

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 125 Birkhead St.

2-FULL NAME: Anna May Travers.

(a) RESIDENCE NO. 125 Birkhead St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)

Female

White.

Single.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 22, 1928

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

0

0

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

10 NAME OF FATHER

Thomas H. Travers

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Susanna Peters.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant  
(Address)Susanna Travers. (mother)  
125 Birkhead St.

15 Filed....., 19

REGISTERED NO.

E 32083

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

23-33

St. Ward

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 25, 1928

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.) and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH was as follows:

Mitral Insufficiency.  
congenital.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

3/26, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place  
of death.....yrs. ....mos. ....ds. In the  
State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Date of Burial

20 UNDERTAKER

J. H. McCully

ADDRESS

178 E. Hill

32084

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

40 E 32084

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *2403 Cager Place* ST., *WARD*)

2-FULL NAME Dominik Hladik

(a) RESIDENCE NO. 2403 Cager Place ST.            WARD             
(Usual place of abode)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed,  
or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24/1891

7 AGE Years Months 1 Days 29- If LESS than 1 day... hrs. or... min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... *Sailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9 BIRTHPLACE** (city or town)  
(State or country)

10 NAME OF FATHER John H. Ladin

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER *Mrs. [illegible]*

13 BIRTHPLACE OF MOTHER (City or town)  
(State or country) *India*

14 Informant Anna H la d'esp  
(Address) 2403 8<sup>th</sup> St. S. S. 55408

15 Filed 19-05-2019

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 19 28

17  
I HEREBY CERTIFY That I attended deceased from

that I last saw him alive on 3-2-2

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) *Chlorophyll*

18 Where was disease contracted if not at place of death?                     

Did an operation precede death? 20 Date of 1

Was there an autopsy? no

What test confirmed deport? *fingerprints*

(Signed) Walter Munk

7/25/2011

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL
---	----------------

DATE OF BURIAL  
 June 26 19 28  
 ADDRESS

20	UNDERTAKER	NAME
21	Geo. M. Finck & Son	ADDRESS
22		811 N. 1st St.

32085

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32085

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *916 N. Parish* *16-22* Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Roy Hall*(a) RESIDENCE NO. *916 N. Parish* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *31* yrs. *3* mos. *26* ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 Color or Race *W*5 Single, Married, Widowed, or Divorced. (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Eva Hall*6 DATE OF BIRTH (month, day, and year) *Nov. 28, 1896*

7 AGE

Years *31*Months *3*Days *26*

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Chauffeur*(b) General nature of industry, business, or establishment in which employed (or employer) *023*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto*

(State or country)

10 NAME OF FATHER *Thomas Hall*11 BIRTHPLACE OF FATHER (City or town) *Ind*

(State or country)

12 MAIDEN NAME OF MOTHER *Maggie Gray*13 BIRTHPLACE OF MOTHER (city or town) *Ind*

(State or country)

14

Informant (Address) *Maggie Tomlin*  
*916 Parish*

15 Filed

MAR 26 1928

C. S. Jones Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 24 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 1* 1928, to *March 24* 1928,that I last saw him alive on *March 24* 1928,and that death occurred, on the date stated above, at *8* A. M.

The CAUSE OF DEATH\* was as follows:

*Carcinoma Stomach*  
(duration) \_\_\_\_ yrs. *1* mos. *24* ds.

CONTRIBUTORY

(Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? \_\_\_\_ Date of \_\_\_\_

Was there an autopsy? \_\_\_\_

What test confirmed diagnosis? \_\_\_\_

(Signed) *B. N. Fletcher* M. D.(Address) *1200 Pe St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *M. Auburn*Date of Burial *Mar 27 1928*

UNDERTAKER

*John H. Chase Son*ADDRESS *1400 M. St*

OF DEATH in plain text. See instructions on back of certificate.





E 32087

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32087

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.)

Lombard Street

WARD 4-30

2-FULL NAME

Harvey McClung

(a) RESIDENCE No.

Richwood W. Va.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

9

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Married to McClung

6 DATE OF BIRTH (month, day, and year)

1878

7 AGE

47 Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hickory Co., W. Va.

10 NAME OF FATHER

Jackson McClung

11 BIRTHPLACE OF FATHER (city or town) (State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Frank L. Goss

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

W. Va.

14

Informant (Address)

University Hosp. Record

15

Filed

JAN 23 1929

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 26 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 17, 1928, to March 26, 1928,

that I last saw him alive on March 26, 1928,

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Brain Abscess

(duration)

yrs.

3

mos.

1

ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes

Date of

3/23/28

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

H. R. Schneider

M. D.

3/27/28 (Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Richwood W. Va.

DATE OF BURIAL

Mar 26 1928

20 UNDERTAKER

Harry N. Witzke

ADDRESS

1531 W. Lombard



E 32089

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Cleveland St.

## 2-FULL NAME

Robert Alfred Just.

REGISTERED NO.

E 32089

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1204 Cleveland St.  
(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 0 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17, 1927.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
0 5 8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Walter Just.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Clara Bischof.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Clara Just. (mother)  
(Address) 1204 Cleveland St.

15 Filed 1928 J. H. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1928

17 I HEREBY CERTIFY, That I attended deceased from March 14th, 1928, to March 25th, 1928.

that I last saw him alive on March 25th 1928 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Acute dilatation of the heart and  
Edema of the Lungs.(duration) yrs. mos. 2 ds.  
CONTRIBUTORY Mitral Insufficiency.  
(Secondary)

Congenital (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.  
(Signed) Otto H. Reinhardt, M. D.

3/25/28 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western Cemetery

Mar 28 1928

20 UNDERTAKER

ADDRESS

Pos J. J. Jones

2178 Penn



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32090

## CERTIFICATE OF DEATH

E 32090  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Sydenham Hospital 22-30*)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Dorothy Howard*(a) RESIDENCE NO. *639 Portland* St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

*Life*

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*July 5, 1927*

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

*9**20*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

*Baltimore*

(State or country)

*Maryland*

10 NAME OF FATHER

*Bert R. Howard*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Tenn.*

12 MAIDEN NAME OF MOTHER

*Rosa McClear*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore**Maryland*

14

Informant

(Address)

*Mrs. Rosa Howard**639 Portland St.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*March 25, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 25, 1928, to March 25, 1928,*that I last saw her alive on *March 25, 1928,*and that death occurred, on the date stated above, at *1:45 p. m.*

The CAUSE OF DEATH\* was as follows:

*Whooping-cough*(duration) \_\_\_\_ yrs. \_\_\_\_ mos. *21* da.

CONTRIBUTORY

(Secondary)

*Pneumonia*(duration) \_\_\_\_ yrs. \_\_\_\_ mos. *?* da.

13 Where was disease contracted

If not at place of death? *At home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *None*

(Signed)

*J. P. Levin*

M. D.

3-26-1928

(Address)

*Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 PLACE OF BURIAL, CREMATION OR REMOVAL

(Date of Burial)

UNDERTAKER

ADDRESS

Registrar

OF DEATH IN BALTIMORE. See instructions on back of certificate. very important.

MAR 26 1928

J. P. LEVIN, M. D.

Registrar

*George R. Ashman*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32091

## CERTIFICATE OF DEATH.

E 32091

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Franklin Square Hosp. 18-76

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mr Andrew Cromwell

(a) RESIDENCE NO.

1020 W. Franklin

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

1 yr.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

16 DATE OF DEATH (month, day, and year) 3-25-28 19

Male

White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ruth B. Cromwell

I HEREBY CERTIFY, That I attended deceased from

3-23-28 19 to 3-25-28 19

that I last saw him alive on 3-25-28 19

6 DATE OF BIRTH (month, day, and year)

Feb 12 1887

7 AGE

Years

Months

Days

If LESS than 1 day, hr. or min.

82

1

13

and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH\* was as follows:

1st - 2nd degree burn of left arm Chest and Shoulder (Fire).

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

not employed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 2 ds.

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

18 Where was disease contracted

at place of death? Home

19 Had an operation precede death? No Date of

Was there an autopsy?

What last confirmed diagnosis? Clinical

(Signed) Gail M. Hall, M.D.

19 (Address) Franklin Square Hosp.

10 NAME OF FATHER

John Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Dollie Gifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

E. B. Cromwell, 900 Equitable Bldg.

15

AR 26 1928

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

National Cem

Mar 27 1928

20 UNDERTAKER

George J. Smith

ADDRESS 1532 Hollins

E 32092

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32092

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Kirkleigh Villa*)2-FULL NAME *Sidney B. Campbell*(a) RESIDENCE NO. *Kirkleigh Villa* St. *Roland Park*

(Usual place of abode)

Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. *6* mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day. hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filed

MAR 26 1928

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

March 23, 1938, to March 24, 1938,

that I last saw him alive on March 24, 1938,

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Degeneration

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

of coronary artery

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Chas. T. Clemente, M. D.

1938 (Address) 1504 W. Center St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Woodbury N. J.

Chas. P. Maus Son 1180 Mt Royal Ave

E 32093

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101 2001  
E 32093

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital 5-8* ST. *5-8* WARD)

### 2-FULL NAME

*Charles Smith*

### (a) RESIDENCE NO.

*301 N. High St*

(Usual place of abode)

Length of residence in city or town where death occurred

*15* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

*Male*

#### 4 COLOR OR RACE

*White*

#### 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

#### 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

*unknown*

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*18*

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

*York, Pa.*

#### 10 NAME OF FATHER

*unknown*

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*unknown*

#### 12 MAIDEN NAME OF MOTHER

*unknown*

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*unknown*

#### 14

Informant (Address)

*Charles Smith 301 N High St*

#### 15

Filed

19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-26-1928*

17

I HEREBY CERTIFY, That I attended deceased from *3-22*, 19 *28*, to *3-26*, 19 *28*.

that I last saw him alive on *3-26*, 19 *28*

and that death occurred, on the date stated above, at *8 A. m*

The CAUSE OF DEATH\* was as follows:

*Laborer pneumonia*

(duration) yrs. mos. *10* ds.

#### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Francis L. Delaplace* M. D.

, 19 (Address) *St Agnes Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

*Catholic Cemetery 3/29/28*

20 UNDERTAKER

*Chas R. Evans Son 1800 Mt Royal Ave*



## HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 32094

## CERTIFICATE OF DEATH.

E 32094

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3007 St. Paul St.

2-FULL NAME Anna Collins Barrett

(2) RESIDENCE NO. 3007 St. Paul St.

(Usual place of sbode)

Length of residence in city or town where death occurred Lifetime

ST, ..... WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Thomas E. Barrett.

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
63				

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work	At Home
--	---------

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) **Name of employer**

9 BIRTHPLACE (city or town) .....  
(State or country) Baltimore Md.

10 NAME OF FATHER Patrick Collins

11 BIRTHPLACE OF FATHER (city or town  
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Stapleton

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Ireland

14 Informant Thomas E. Barrett  
(Address) 3007 St. Paul St.

15 Filed 26-1928 19 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th. 28

17  
I HEREBY CERTIFY, That I attended deceased from  
2-13, 1928, to 3-25, 1928,  
that I last saw her alive on 3-25, 1928  
and that death occurred, on the date stated above, at 28 A m

The CAUSE OF DEATH\* was as follows:

CAUSE OF DEATH\* was as follows:

*Arrhosis of Liver*  
*myocarditis.*

(duration) yrs. 8 mos. ds.  
CONTRIBUTORY *Pulmonary* *Edema*  
(Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted  
if not at place of death?.....

Did an operation precede death? no Date of

### Was there an autopsy?

What test confirmed diagnosis Cerebral Palsy  
(Signed) W. H. Adams, M. D.

, 19 (Address) 1403 Oaklaze

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL  
Cathedral Cemetery

DATE OF BURIAL

3/28 28.

ADDRESS

## Registrar

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32095

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *North Hope Retmat* ST. *28th* WARD)

### 2-FULL NAME

*James Flynn*

### (a) RESIDENCE NO.

*North Hope Retmat* ST. *28th* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

*48* yrs.

*0* mos.

*0* ds.

How long in U. S., if of foreign birth?

*Life* yrs.

*0* mos.

*0* ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32095

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

*Male*

#### 4 COLOR OR RACE

*White*

#### 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

#### 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*X*

#### 6 DATE OF BIRTH (month, day, and year)

*Sept 7, 1863*

#### 7 AGE

*64* Years

*06* Months

*17* Days

If LESS than 1 day, hrs. or min.

#### 8 OCCUPATION OF DECEASED

##### (a) Trade, profession or particular kind of work

*None*

##### (b) General nature of industry, business, or establishment in which employed (or employer)

*X*

##### (c) Name of employer

*X*

#### 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

#### 10 NAME OF FATHER

*James Flynn*

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*(?) Ireland*

#### 12 MAIDEN NAME OF MOTHER

*Mary White*

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*(?) Ireland*

#### 14

##### Informant (Address)

*Records of Mt Hope Retmat Mt Hope Balt Md.*

#### 15

##### Filed

*19*

*Samuel Jones, Jr. Registrar*

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

*March 24th 1928*

#### 17

I HEREBY CERTIFY, That I attended deceased from *May 1881* to *March 24*, 19*28*, that I last saw him alive on *March 24*, 19*28*, and that death occurred, on the date stated above, at *11:30 P.* m. The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*

*3 or 4* yrs. *0* mos. *0* ds. (duration)

#### CONTRIBUTORY (Secondary)

*Terminal pneumonia of Chronic nature* (duration) *48* yrs. *0* mos. *0* ds.

#### 18 Where was disease contracted if not at place of death?

*Baltimore Md.*

#### Did an operation precede death?

*No* Date of *0*

#### Was there an autopsy?

*No*

#### What test confirmed diagnosis?

(Signed) *Frank J. Flannery*, M. D.

*March 25, 1928* (Address) *N. Hope Retmat - Balt Md.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-

#### DATE OF BURIAL

*Cathedral Cemetery* *3/26* 19*28*

#### UNDERTAKER

#### ADDRESS

*Chas. F. Wares & Son 118 W. Mt Royal Ave*

tion is very important



E 32097

Cullen  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

114 ✓  
REGISTERED NO.

E 32097

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Little Sisters of the Poor* 10-14 Ward)

## 2-FULL NAME

*Kate Cullen*

## (a) RESIDENCE NO.

*Preston & Valley*

St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*F*

## 4 Color or Race

*W*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*unknown*

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.*64*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

*Ireland*

## 10 NAME OF FATHER

*William Cullen*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Ireland*

## 12 MAIDEN NAME OF MOTHER

*Anna Cullen*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ireland*

## 14

Informant  
(Address)*Little Sisters of the Poor  
Preston & Valley St.*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19 *28**March 25th*

## 17

I HEREBY CERTIFY, That I attended deceased from

*3/18/28* 19 *28* to *3/25/28*

that I last saw him alive on

*3/24/28* 19 *28*and that death occurred, on the date stated above, at *2* m.

The CAUSE OF DEATH was as follows:

*Chronic Enterocolitis*

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY

(Secondary)

*Arteriosclerosis**unknown*

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Dr. Donald Ross* M. D.

(Address)

*914 I Biddle St*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Cathedral**Mar 27 1928*

## 20 UNDERTAKER

ADDRESS

*Rita Wiedefeld 914 Greenport Ave*

very important. See instructions on back of card.

R 26 1928

G. S. JONES, R. D.  
Registrar



32098

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 32098  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *City Hospital* ST. *10-14* WARD)

## 2-FULL NAME

*Corneilus P. Judge*

## (a) RESIDENCE NO.

*Biddle & Valley Sts.*

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*M.**White**Single*

a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*1865*

DATE OF BIRTH (month, day, and year)

*1965*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*63*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Washington D.C.*

10 NAME OF FATHER

*Charles Judge*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Ireland*

12 MAIDEN NAME OF MOTHER

*unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Ireland*

14

Informant  
(Address)*Hospital Record  
Baltimore City Hospital*

15

Filed

AR 26 1928

Per

Registree

Registree

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 28 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 12, 1928, to March 25, 1928.*that I last saw him live on *March 25, 1928*and that death occurred, on the date stated above, at *1:15 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary etc.**unknown* (duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?*unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

*Terminal & Autopsy*

(Signed)

*L. M. S. M. D.*

3/25/28 (Address)

*Balto. City Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Cathedral**Mar 27 1928*

20 UNDERTAKER

ADDRESS

*Bila Wiedefeld 914 Greenback Rd*

32099

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Forrest

2-FULL NAME Frances Dolan Fannon

(a) RESIDENCE No. 1104 Forrest

(Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. *1* mos.

ST. *10-14* WARD

REGISTERED NO. *44 E 32099*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. *10-14* WARD

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

If married, widowed, or divorced HUSBAND of (or) WIFE of

*William P. Fannon*

DATE OF BIRTH (month, day, and year) *Apr. 23. 1870*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*57 11 1*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*

10 NAME OF FATHER *Edw. Dolan*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*

12 MAIDEN NAME OF MOTHER *Eliz. Riley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14 Informant *Mrs. J. J. Alexander*

(Address) *Glenburnie, Md*

15

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 24 1928*

17 I HEREBY CERTIFY, That I attended deceased from *January 13, 1928* to *March 24, 1928*.  
that I last saw her alive on *March 24, 1928*,  
and that death occurred, on the date stated above, at *5 P. m.*  
The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach*  
(duration) *1* yrs. *1* mos. *21* ds.

CONTRIBUTORY (Secondary)

*Acute myocarditis*  
(duration) *1* yrs. *1* mos. *21* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Laboratory etc*

(Signed) *Frank J. Ayers* M. D.  
*March 26, 1928* (Address) *2005 B. Monument St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Cathedral*

DATE OF BURIAL

*Mar. 27, 1928*

20 UNDERTAKER

ADDRESS

*Edith Windefield 914 Greenbush Ave*

**MAR 26 1928**

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32100

## CERTIFICATE OF DEATH

E 32100

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. *11-24* Ward)

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *64 Spring St. Brockton, Mass.* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *23* ls. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

*Male white Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Oct 16, 1859*

7 AGE Years Months Days IF LESS than 1 day hrs. or min..

*66 5 10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

MAR 26 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17

I HEREBY CERTIFY, That I attended deceased from

*3/11, 1928, to 3/26, 1928*that I last saw him alive on *3-26, 1928*and that death occurred, on the date stated above, at *7 A. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach*

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32101

## CERTIFICATE OF DEATH.

90 E 32101

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1282 Light St.

## 2-FULL NAME

Valentine Hartlieb.

(a) RESIDENCE NO. 1282 Light St.

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 45 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male.

White.

Married.

5a If married, XXXXXXXX  
HUSBAND of

XXXXXXXXXX

Rose Hartlieb.

6 DATE OF BIRTH (month, day, and year)

January 1, 1856

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

72

2

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Marble polisher

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany.

10 NAME OF FATHER

Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany.

14

Informant

Rose Hartlieb. (wife)

(Address)

1282 Light St.

Filed 26 1928

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 24, 1928

192

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular disease of the Heart.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

M. D.  
(Coroner)

8/26/1928 (Address) 1017 S. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

In the

of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Holy Cross Cem., A. A.

March 25 1928

20 UNDERTAKER

ADDRESS

Margaret G. Flynn

1282 Light St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32102

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital 24-34)2-FULL NAME Nellie M. Ford(a) RESIDENCE NO. 1401 William St

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs.St. W Ward

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

widowed

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofJoe. M. Ford

6 DATE OF BIRTH (month, day, and year)

Feb. 19, 1874

7 AGE

Years

54

Months

1

Days

5

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workProprietress(b) General nature of industry,  
business, or establishment in  
which employed (or employer)Confectionary store

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Howard Co., Md

10 NAME OF FATHER

Joe. Harding

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Howard Co., Md

12 MAIDEN NAME OF MOTHER

Mary Edelen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Howard Co., Md

14

Informant  
(Address)Mildred Ford  
1401 William St.

MAR 26 1928

Registrar

REGISTERED NO.

E 32102

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 25/28

17

I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.)And that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Septic Peritonitis (No operation  
Ruptured Appendix or autopsy)  
(duration) ..... yrs. .... mos. .... ds.CONTRIBUTORY  
(Secondary)

(Signed)

J. S. H. B.  
(Coroner)

(Address)

508 E. North Ave\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place of death..... yrs. .... mos. .... ds. In the  
State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Date of BurialCathedral Cem.March 28, 1928

UNDERTAKER

Margaret L. Flynn

ADDRESS

1422 Light St

very important. See instructions on back of card

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32103

## CERTIFICATE OF DEATH.

129 E 32103

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1825 N. Dallas

ST. 8-17 WARD)

### 2-FULL NAME

Mary E. Hamilton

### (a) RESIDENCE NO.

(Usual place of abode)

1825 N. Dallas

ST. WARD

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### SEX

Female

#### 4 COLOR OR RACE

White

#### 5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

Sept 1871

#### 7 AGE

Years

Months

Days

If LESS than 1 day.....hrs or.....min.

56

6

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

Md

#### 10 NAME OF FATHER

George J. Hamilton

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

#### 12 MAIDEN NAME OF MOTHER

Bridget Harkins

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

#### 14

Informant (Address)

Ed J. Jenkins 734 Granthly St

#### 15

Filed

20

R. J. [Signature] Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

Mar 25 1928

#### 17

HEREBY CERTIFY, That I attended deceased from Mar 3, 1928 to Mar 25, 1928.

that I last saw him alive on Mar 25, 1928.

and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

#### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

#### 18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed) Walter W. White Jr., M. D.

26 1928 (Address) 2800 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St Vincent

#### 20 UNDERTAKER

W. Cook

#### DATE OF BURIAL

3/27 1928

#### ADDRESS

500 E. [Address]

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32104

## CERTIFICATE OF DEATH.

44 E 32104

## 1. PLACE OF DEATH

CITY OF BALTIMORE: No. 2527 Barclay

12-50 WARD

## 2. FULL NAME

William J. Schmidt

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No.

2527 Barclay

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

M

4 COLOR OF RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Anna E. Schmidt

6 DATE OF BIRTH (month, day, and year)

Apr 29, 1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

10

25

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Hard wood finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Union Mem. Shop

9 BIRTHPLACE (city or town) (State or country)

Balt Md

10 NAME OF FATHER

Henry Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Hannah Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Conn

14

Informant (Address)

J. R. Schmidt 2527 Barclay St

15

Filed

MAR 27 1928

BALTIMORE, MD.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 24 1928

17

HEREBY CERTIFY, That I attended deceased from

Feb 2nd, 1928, to March 2nd, 1928.

that I last saw him alive on March 2nd, 1928,

and that death occurred, on the date stated above, at 8:10 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray Exam.

(Signed) Geo. J. Ferguson, M.D.

3/16/28 Address 4008 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral

3/27 1928

20 UNDERTAKER

ADDRESS

J. M. Cook

522 E. North Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32105

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1736 E. Chase*)

2-FULL NAME *John Stober*

(a) RESIDENCE NO. *1736 E. Chase*  
(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

ST. *8-13* WARD

REGISTERED NO.

E 32105

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

*M*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar 11, 1842*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*86*

*0*

*14*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balt. Md*

10 NAME OF FATHER

*Jacob Stober*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Rebecca Ostmann*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Eugenia Kimmeth 1736 E. Chase St*

15

Filed

*1928*

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 25 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 21*, 1928, to *Mar 25*, 1928, that I last saw him alive on *Mar 24*, 1928, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Chronic Bronchitis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Old age*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*3/26/28*

(Address)

*2800 87 Park St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

*New Cathedral*

UNDERTAKER

*Wm Cook*

DATE OF BURIAL

*3/28 1928*

ADDRESS

*502 E North Ave*



12109  
32106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)

2-FULL NAME

Carrie M<sup>c</sup> Chestney

(a) RESIDENCE No.

460 S. Benton ST.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

City

(If non-resident give city or town and State)

REGISTERED 129 32106  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Joseph

DATE OF BIRTH (month, day, and year)

1902

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None - 007

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country)

La.

12 MAIDEN NAME OF MOTHER

Perie Stottuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

La.

14

Informant (Address)

Reynolds

15

Filed

MAR 27 1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 25 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar. 16 1928 to Mar. 24 1928.

that I last saw her alive on Mar. 24 1928.

and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis (diffuse)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uremia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood chemistry & autopsy

(Signed) Christopher Johnston M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOV.

St. Patrick Cemetery

20 UNDERTAKER

Wm. Cook

DATE OF BURIAL

3/28 1928

ADDRESS

502 E. Park

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32107

## CERTIFICATE OF DEATH.

90 E 32107

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 510 N. Gay St. St. 5-8 Ward)

2-FULL NAME David P. Shields

(a) RESIDENCE NO.

510 N. Gay St

St.

Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. 2/ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

white

5 Single, Married, Widowed, or Divorced, (write the word)

widower

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Catherine Shields

6 DATE OF BIRTH (month, day, and year)

March 6/1867

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....mins.

61

0

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Leather Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Penna.

10 NAME OF FATHER

David Shields

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

B

14

Informant  
(Address)

Gep. T. Davis

510 N. Gay St.

15

Filed

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Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry

topsy or inquiry.) filed that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probable Rt. Hemiplegia

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

Chr. Myocarditis

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner)

(Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

In the

of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Very Important. See Instructions on back of card.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E-32108

## CERTIFICATE OF DEATH.

29 E 32108

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Med General Hosp* *20-69* Ward)2-FULL NAME *Chas. Parks*(a) RESIDENCE NO. *2426 Wilkins Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Single*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Apr 27-1917*

## 7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

*10 10 30*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*School*

## 9 BIRTHPLACE (city or town)

(State or country)

*Baltimore Md*10 NAME OF FATHER *Chas Parks*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Md*12 MAIDEN NAME OF MOTHER *May & Brown*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Md*

## 14

Informant

(Address)

*Hosp. records*

## 15 Filed

AK 27 1928

Per

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

*Mar 26-*17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Tetanus*

## CONTRIBUTORY

*left eye*

(Signature)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Oak Grove*

## 20 UNDERTAKER

*Wm. C. Calk*

Date of Burial

*3/29 1928*

ADDRESS

*502 E. Park Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32109

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

(a) If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

May Authman

6 DATE OF BIRTH (month, day, and year)

Aug 1<sup>st</sup> 1848

7 AGE

Years

Months

Days

If LESS than  
1 day, ... hrs.  
or ... min.

79

7

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

at home

9 BIRTHPLACE (city or town)  
(State or country)

Germany.

10 NAME OF FATHER

not known

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna C. Gredt

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant

Emil Hoodman

(Address)

666 N. Franklin St.

15

FILED

AR 27 1928

SARSON, J. L.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3 - 24 19 28

17

I HEREBY CERTIFY, That I attended deceased from

July 29, 19 28, to Aug 24, 19 28

that I last saw her alive on

Aug 22, 19 28

and that death occurred, on the date stated above, at

10 A m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

R. Gustav Dill, M. D.

(Address)

1509 N. Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western Cre

3-27 19 28

20 UNDERTAKER

ADDRESS

Mrs. Charles G. Redder, 2321 Edmond St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32110

## CERTIFICATE OF DEATH.

117 E 32110

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST. *9-46* WARD)2-FULL NAME *Ellen Healy*(a) RESIDENCE NO. *2417 Ainsworth* ST. *9-46* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. *3* mos. *18* ds.How long in U. S., if of foreign birth? *Life* mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Mar. 18 1924*

AGE

Years *3*Months *3*Days *8*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Beth Md.*  
(State or country)10 NAME OF FATHER *Thomas J. Healy*11 BIRTHPLACE OF FATHER (city or town) *Beth Md.*  
(State or country)12 MAIDEN NAME OF MOTHER *Marie Zimmerman*13 BIRTHPLACE OF MOTHER (city or town) *Beth Md.*  
(State or country)

14

Informant *M. Thomas J. Healy*  
(Address) *2417 Ainsworth St.*

15

Filed *27 1928*Registrar *W. J. C.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/26/1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 23, 1928*, to *March 26, 1928*.that I last saw her alive on *March 26, 1928*.and that death occurred, on the date stated above, at *8:38 a.m.*

The CAUSE OF DEATH\* was as follows:

*Ruptured appendix  
& general peritonitis*(duration) yrs. mos. *7* ds.CONTRIBUTORY (Secondary) *Intestinal obstruction*(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *3/23/28*Was there an autopsy? *No*What test confirmed diagnosis? *Symptoms & signs*(Signed) *J. MacLagana*

M. D.

19

(Address) *St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Holy Redeemer Cemetery*DATE OF BURIAL *March 28 1928*20 UNDERTAKER *Henry Hoek*ADDRESS *1301 E. Eager St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32111

## CERTIFICATE OF DEATH.

90 ✓  
E 32111  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 817 Aisquith St St 10-24 Ward)

## 2-FULL NAME

Edward Rinehart

(a) RESIDENCE NO. 817 Aisquith St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 47 mos.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

male white single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day...hrs. or...min.

47

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Concrete Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City 083

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

10 NAME OF FATHER George Rinehart

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Alverta Morgan

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Balto. Md.14 Informant Laura Rinehart  
(Address) 817 Aisquith St

MAR 27 1928

J. J. Jones, Jr. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.  
(Signed) J. J. Jones, Jr. M. D.  
(Coroner)

3/26/28 (Address) 503 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park Cemetery March 28, 28

20 UNDERTAKER

ADDRESS

Henry Black Low 1301 E. Bay St.

E 32112

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 32112

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 S. Ann ST. 2-4 WARD)

2-FULL NAME Alexandra Czycier

(a) RESIDENCE NO. 225 S. Ann ST. 2-4 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Vicenty Czycier

DATE OF BIRTH (month, day, and year) 5/22/1884  
AGE Years 43 Months 10 Days 3 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) Homework  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland  
10 NAME OF FATHER John Ryciak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER M. Krown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant (Address) Vicenty Czycier 225 S. Ann

15 Filed 27 1928 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to March 26, 1928, that I last saw her alive on March 26, 1928, and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH\* was as follows:  
Acute cardiac dilatation

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

Signed John V. Seibert, M. D. 3/26/28 (Address) 1738 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Rosary DATE OF BURIAL 3/27 1928

ADDRESS 1618 Eastern

E 32113

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 32113

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 N. Eden

## 2-FULL NAME

Sarah Blow

## (a) RESIDENCE NO.

723 N. Eden

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos.

Life

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

C

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

~~HUSBAND~~ or  
(or) WIFE of

Wm. McKinley Blow.

## 6 DATE OF BIRTH (month, day, and year)

unknown

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

approx 26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

house work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

at home

## (c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto Md

## 10 NAME OF FATHER

Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Pa.

## 12 MAIDEN NAME OF MOTHER

Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Pa.

## 14

Informant  
(Address)Samuel (uncle) (step-father)  
723 N Eden st.

## 15

Filed

19

Registrar

ST. 10-13 WARD

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1928

17

I HEREBY CERTIFY, That I attended deceased from

Dec 1927 to March 24 1928.

that I last saw him alive on March 22 1928

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Hemorrhage  
Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY  
(Secondary)Pulmonary Hemorrhage  
(duration) yrs. mos. 1 ds.18 Where was disease contracted  
if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical

(Signed)

2/26/28

(Address)

1429 E Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Cemetery

## DATE OF BURIAL

March 27, 28

## ADDRESS

1502  
E Monument

## 20 UNDERTAKER

John W. Henderson





2310  
E 32115

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32115

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)ST. 6-9 WARD)

## 2. FULL NAME

Donald Kavanagh

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

20 N - Washington St

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

(If non-resident give city or town and State)

Life yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Child

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

9-28-27

AGE

Years

Months 5Days 1

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind -

10 NAME OF FATHER

Thomas Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind -

12 MAIDEN NAME OF MOTHER

Doris Kavanagh

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind

14

Informant (Address)

Records -

15

Date

MAR 27 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 25 - 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar - 22 - 1928, to Mar - 25 - 1928.that I last saw him live on Mar - 25 - 1928.and that death occurred, on the date stated above, at 4 20 PM.

The CAUSE OF DEATH\* was as follows:

Primary Bronchopneumonia(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) Albert Blossone, M. D.19 (Address) The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Mt Carmel cemetery - March 27 1928

UNDERTAKER

ADDRESS

George J. Ruth - 1735 Hayford Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32116

## CERTIFICATE OF DEATH.

100-001  
E 32116

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

JOHNS HOPKINS HOSPITAL

ST. 28-64 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Crockett

(a) RESIDENCE NO. 5200 Wesley Ave. Howard Park

(Usual place of abode)  
Length of residence in city or town where death occurred 4 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C. Crockett

DATE OF BIRTH (month, day, and year) Oct. 3 1903

AGE Years Months Days If LESS than 1 day, hrs. or min.  
24 5 21

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Samuel Streett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Rutledge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Records

15 MAR 27 1928 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1928, to Mar. 24, 1928, that I last saw her alive on Mar. 24, 1928, and that death occurred, on the date stated above, at 11:26 P. M.  
The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

CONTRIBUTORY (Secondary) Empyema (duration) yrs. 2 1/2 mos. ds. (history)

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3/16/28

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory (Signed) W. Lindsay Miller, M. D. 3/25 1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Bethel Cem, Madonne, Md.

20 UNDERTAKER

George W. Ginkle

DATE OF BURIAL

3/27 1928

ADDRESS

1737 E. Eager St.

32117

## HEALTH DEPARTMENT—CITY OF BALTIMORE

44E 32117

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 S Seventh

## 2-FULL NAME

John Weber, Jr.

## (a) RESIDENCE

No. 818 S Seventh

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

ST. WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

76-37

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Catherine Weber

## DATE OF BIRTH (month, day, and year)

Jan. 24-1845

## AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

83

2

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md

## 10 NAME OF FATHER

Carl Weber

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

don't know

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

don't know

## 14

Informant  
(Address)Mrs. Conrad Rosemark  
818 S. Seventh St.

## 15

Filed

19

R. L. G. S. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 25 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Oct. 1927, to March 24, 1928.

that I last saw him alive on March 24, 1928.

and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Starvation

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death?

No Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Clinical &amp; Microscopic

(Signed)

J. H. Schell, M. D.

3/26/28 (Address) 2207 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oaklawn Cemetery

## DATE OF BURIAL

3/28 1928

## 20 UNDERTAKER

George W. Zirkler

## ADDRESS

1737 E. Eager St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32118

## CERTIFICATE OF DEATH

E 32118  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3329 Beech Ave.

S. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh G. Shelley.

(a) RESIDENCE NO. 3329 Beech Ave.

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male.	white.	married.

5a If married, widowed, or divorced

husband of Laura E. Shelley

6 DATE OF BIRTH (month, day, and year) Feb. 22/1859.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
69.		1.	4.	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Co. Maryland.  
(State or country)

10 NAME OF FATHER Edward Shelley.

11 BIRTHPLACE OF FATHER (City or town)  
(State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown.14 Informant Mrs. Laura E. Shelley (wife).  
(Address) 3329 Beech Ave.

15 Filed G. S. JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 March. 26th. 1928.

17

I HEREBY CERTIFY, That I attended deceased from

March 20, 1928, to March 26, 1928.

that I last saw him alive on March 25, 1928.

and that death occurred, on the date stated above, at 3-15. A.M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

CONTRIBUTORY (duration) yrs. mos. 1 da.  
(Secondary) Pulmonary edema

(duration) yrs. mos. 1/2 da.

18 Where was disease contracted Home

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Exam. &amp;

(Signed) M. D.

Mar 26, 1928 (Address) 3429 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cemetery.

Date of Burial

3/29/1928.

20 UNDERTAKER J. Walter Jones, 307. Paine. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32119

## CERTIFICATE OF DEATH

129 E 32119

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital*)St. *18-27* Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Paul Kenny*(a) RESIDENCE NO. *1403 Edmondson Ave.*

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. *1* mos. *0* ds. How long in U. S. if of foreign birth? *4* yrs. *1* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*July 6th 1879*

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

*48**8**19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Auto. Rental*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Maryland*

10 NAME OF FATHER

*John Kenny*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Mary A. Brown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ireland*

14

Informant (Address)

*Michael B. Kenny 1403 Edmondson Ave.*

15 Filed

*C. R. Jones, R. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/15/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*3/16/28*, 19, to *3/25/28*, 19that I last saw him alive on *3/25/28*, 19and that death occurred, on the date stated above, at *12:30* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Disease Glomerula Nephritis*(duration) *1* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *—* Date of *—*Was there an autopsy? *L*What test confirmed diagnosis? *Clinical*(Signed) *J. S. Winstead*, M. D., 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*New Cathedral Cem.**March 28 1928*

20 UNDERTAKER

*Charles F. Hill*ADDRESS *3109**Fredricka*

AR 27 1928

E 32120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 32120

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1306 Madison Ave. 11-24

2-FULL NAME Louisa Perry

(a) RESIDENCE, NO. 1306 Madison Ave. T.

Length of residence in city or town where death occurred Don't know 1 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE col 5 Single, Married, Widowed, or Divorced (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of L. Carl Perry

6 DATE OF BIRTH (month, day, and year) 9/10/1882

7 AGE 46 Years 13 Months 13 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

10 NAME OF FATHER Chas. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Adel Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Adel Ryzard 1306 Madison Ave.

AR 27 1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23 1928

17 I HEREBY CERTIFY, That I attended deceased from 3, 20 - 1928, to 3, 23, 1928, that I last saw her alive on 3, 22 - 1928, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH\* was as follows:

Valvular Heart disease

(duration) Don't know 1 ds.

CONTRIBUTORY (Secondary) Don't know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. G. M. D.

326, 1928 Address 117 W. Lexington St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mr. Alburn Canfield 27

20 UNDERTAKER Mrs. J. G. Locks 1302 1/2

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32121

## CERTIFICATE OF DEATH.

129 E 32121

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *916 N. 11th St.* ST. *16-39* WARD)

### 2-FULL NAME

*Eva, V. Davis*

### (a) RESIDENCE NO.

*916 N. 11th St.*

(Usual place of abode)

ST. *16-39* WARD

WARD

Length of residence in city or town where death occurred

*Lif.*

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female*

*White*

*Married*

If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Wm. T. Davis*

DATE OF BIRTH (month, day, and year)

*Jan 7-1871*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*57*

*2*

*18*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balte. Md.*

10 NAME OF FATHER

*John Macmillan*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balte*

12 MAIDEN NAME OF MOTHER

*Marion Brun*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balte*

14

Informant (Address)

*Wm. T. Davis 916 N. 11th St.*

15

Filed

*27 1928*

*Wm. T. Davis, R. E. Registrar*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 25 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 8*, 1928, to *March 25*, 1928, that I last saw her alive on *Mar. 24*, 1928, and that death occurred, on the date stated above, at *10:30* m.

The CAUSE OF DEATH\* was as follows:

*Nephritis and Myocarditis*

(duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Dropsy*

(duration) *1* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *---*

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical*

(Signed) *Edwin B. Ferry*, M. D.

*3/25/1928* Address *1223 N. Caroline St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Baltimore Cem*

DATE OF BURIAL

*Mar 27 1928*

20 UNDERTAKER

*Geo M. Link*

ADDRESS

*811 Newry*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32122

E 32122

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town  
(State or country))

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

Filed

R 27 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Jan 31, 1928, to Mar 24, 1928,  
that I last saw her alive on Mar 24, 1928,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Carcinoma of Caecum  
with extensive Metastases  
and Intestinal Obstruction

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? Yes Date of 2-8-28

Was there an autopsy? No

What test confirmed diagnosis? Clinical &amp; Operative

(Signed) G. O. Eaton M. D.

19 (Address) Ben Securo Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19-PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

E 32123

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32123

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2712 Jefferson ST., 7-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Caroline Dieter(a) RESIDENCE NO. 2712 Jefferson ST., 7-10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) WidowIf married, widowed, or divorced  
HUSBAND of John G. Dieter  
(or) WIFE ofDATE OF BIRTH (month, day, and year) Dec 29 - 18807 AGE Years 77 Months 2 Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER John Hinderer11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Don't know13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant Mrs Mary Clark  
(Address) 2712 Jefferson

15

Filed 1928

19

By R. H. H.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1928

17

I HEREBY CERTIFY That I attended deceased from March 19, 1928 to March 27, 1928, that I last saw her alive on March 26, 1928, and that death occurred, on the date stated above, at 430 A m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Breast

CONTRIBUTORY (Secondary)

(duration) 7 yrs. 0 mos. 0 ds.Cachexia and Metastasis(duration) 6 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical Examination(Signed) Albert Osbourne, M. D.3/27/1928 (Address) 7025 E North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Rouzon Park CemDATE OF BURIAL Mar 27 192820 UNDERTAKER John MillerADDRESS 2008 Orleans

E 32124

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3311 E Pratt St., 76-37 Ward)2-FULL NAME Herman O Paul(a) RESIDENCE NO. 3311 E Pratt St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced

HUSBAND of \_\_\_\_\_

(or) WIFE of \_\_\_\_\_

Anna E Huether

6 DATE OF BIRTH (month, day, and year)

Oct 11 - 1873

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

37513

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany10 NAME OF FATHER Fritz Paul

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany12 MAIDEN NAME OF MOTHER Henrika Fuchs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant Ms Anna Paul(Address) 3311 E Pratt St

15 Filed

R 27 1928

J. J. JONES, R. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1928

17

I HEREBY CERTIFY, that I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

Inquest, autopsy or inquiry.

person and from the evidence obtained by said

Inquest, autopsy or inquiry.

and that said deceased came to death

top of inquiry.

on the day stated above.

The CAUSE OF DEATH was as follows:

Acc. To PoisoningIll.

CONTRIBUTORY (Secondary)

Mar 24/28

(Signed)

19

(Address)

Education \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

M. D.

(Coroner)

143 W 13 way

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., .....mos., .....ds. In the State.....yrs., .....mos., .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Oak Lawn CemJohn Ulrich

Date of Burial

Mar 28

ADDRESS

7608 Orleans

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32125

## CERTIFICATE OF DEATH.

43 E 32125

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1254 N. Broadway* - *13* ST. *Ward*)2. FULL NAME *Dr. Geo. F. Taylor*(a) RESIDENCE NO. *1254 N. Broadway* ST. *Ward*

(Usual place of abode)

Length of residence in city or town where death occurred *72* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Mary Janet*DATE OF BIRTH (month, day, and year) *Aug 17 - 1880*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*71**7**8*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Physician*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Baltimore*10 NAME OF FATHER *James Taylor*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*York Pa*12 MAIDEN NAME OF MOTHER *Elizabeth Church*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore*

14

Informant  
(Address)*Mr. Mary Taylor*  
*1254 N. Broadway*

15

AR 27 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 25 - 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*May 1, 1927, to Mar 25, 1928,*that I last saw him alive on *Mar 25, 1928*  
and that death occurred, on the date stated above, at *7:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Cancer of tongue & throat*(duration) yrs. *11* mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Robt. Davis*, M. D., 19 (Address) *1509 N. Caroline St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Green Ridge Cem**Mar 28, 1928*

20 UNDERTAKER

ADDRESS

*John Walker**2008 Orleans*



32126

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32126

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2425 Barclay ST. 12-50 WARD)2-FULL NAME Mary E Layfield(a) RESIDENCE NO. 2425 Barclay ST. 12-50 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 25 1928

17

I HEREBY CERTIFY, That I attended deceased from  
March 22nd 1928, to March 25th 1928,that I last saw her alive on March 24th 1928and that death occurred, on the date stated above, at 6-2 a. m.

The CAUSE OF DEATH\* was as follows:

Acute Cordiac DilatationCONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address)

Physical Exam  
Geo. H. Gormley III, M. D.  
1401 E 25th St\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park Cem  
John W. WicksMar 28 1928  
208 E  
Chesapeake

HEALTH DEPARTMENT - CITY OF BALTIMORE

32127

CERTIFICATE OF DEATH.

90 E 32127  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3616 Old Fred Road St. 70-70 Ward)

2-FULL NAME Ellen M. Cahill

(a) RESIDENCE NO. 3616 Old Fred Road St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Jan 16, 1846

7 AGE Years \_\_\_\_\_ Months 2 Days 9 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ (c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Baltimore (State or country) \_\_\_\_\_

10 NAME OF FATHER John Cahill

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Dunn

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country) \_\_\_\_\_

14 Informant Miss Barbara M. Carter (Address) 2616 Old Fred Road

15 Filled C. B. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/28

17 I HEREBY CERTIFY, That I attended deceased from 3/20/28, 19\_\_\_\_, to 3/25/28, 19\_\_\_\_, that I last saw him alive on 3/24/28, 19\_\_\_\_, and that death occurred, on the date stated above, at 11:58 m.

The CAUSE OF DEATH\* was as follows: Art. sclerosis

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY Rheumatism (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds. ?

18 Where was disease contracted \_\_\_\_\_ If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? none

(Signed) Barney T. King, M. D. 3/27/1928 (Address) 110 W. Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial 3-28-1928

20 UNDERTAKER H. B. Branning ADDRESS 1136 E. B. Branning

very important. See instructions on reverse side.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32128

## CERTIFICATE OF DEATH.

32128

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Marshall)

ST. 24-34 WARD

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Myrtle Caldwell

(a) RESIDENCE NO. 1509 Marshall

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female.

White.

Infant.

If married, widowed, or divorced

HUSBAND of (or) WIFE of

Infant.

DATE OF BIRTH (month, day, and year) March, 26, 1928.

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Robert M. Caldwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Anna Kinsley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Robert Caldwell (Address) 1509 Marshall St.

15 Filed... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1928, to March 26, 1928.

that I last saw ~~at~~ alive on March 26, 1928

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Uremic apoplexy.

CONTRIBUTORY (Secondary) Face paronychia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirm diagnosis?

(Signed) John A. Scheuerich, M. D.

, 19 (Address) 1337 S. Charles St.

\*State (1) Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

London Pk Cem March 27, 1928

20 UNDERTAKER ADDRESS

A. Howard Evans & Son

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32129

## CERTIFICATE OF DEATH.

178 E 32129

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 6-9 Ward)2-FULL NAME Morris Silver(a) RESIDENCE NO. 200 N. Ann St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed or divorced, HUSBAND of (or) WIFE of Annie Silver6 DATE OF BIRTH (month, day, and year) 19007 AGE Years 28 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Store

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Russia10 NAME OF FATHER Harry Silver11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Hinda Pinkus13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia14 Informant J Lewis(Address) 1439 E. Balto. St.

15 Filed.....19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidental Burns over body.  
(Home caught fire in unknown manner was asleep on 2nd floor)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [Signature] M. D. (Coroner)3/26/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 7-27-28

## 20 UNDERTAKER

ADDRESS 1439 E. Balto. St.



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32130

## CERTIFICATE OF DEATH.

E 32130

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1408 Traction*)

ST. *13-59* WARD

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

*John Brooks*

### (a) RESIDENCE NO.

*1408 Traction*

ST. *13-59* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*2* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male*

*Colored*

*Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Oct 26 1925*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2*

*7*

*30*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*Albion Richardson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md*

12 MAIDEN NAME OF MOTHER

*Carrie Brooks*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md*

14

Informant (Address)

*Carrie Brooks 1408 Traction*

15

Filed

MAR 27 1928

*John Brooks, K. D. Registrar*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 25 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 16 1928* to *Mar 25 1928*

that I last saw him alive on

*Mar 24 1928*

and that death occurred, on the date stated above, at

*2 P. m.*

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*William H. M. D.*

326 1928 (Address)

*1928 Penna Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Mt Auburn*

*Mar 27 1928*

20 UNDERTAKER

ADDRESS

*Virginia Brooks 14637 Cany*

32131

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 32131

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 Warren Ave.

ST. 22-33 WARD

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Lucy May Young

### (a) RESIDENCE NO.

222 Warren Ave.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Mar. 18, 1874

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

0

7

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

City

9 BIRTHPLACE (city or town) (State or country)

Winchester, Va.

### 10 NAME OF FATHER

George M. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER Lucinda Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant

(Address)

Philip Young (Brother) 401 - 68 St Phila Pa.

15

Filed

19

27-1928 REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25, 19 28

17

I HEREBY CERTIFY, That I attended deceased from

Mar 20, 19 24, to Mar 20, 19 25

that I last saw her alive on Mar 20, 19 25

and that death occurred, on the date stated above, at 1.42 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic valvular disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

3/25/1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Winchester Va - via B. & O. R.R.

Mar 28 1928

20 UNDERTAKER

ADDRESS

John F. Denny

75 Light St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32132

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 537 Dolphin St. 17-24 Ward)

2-FULL NAME Winnie Campbell

(a) RESIDENCE NO. 537 Dolphin St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)  
Length of residence in city or town where death occurred

\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

129 ✓  
E 32132  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Col. 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) June 8 - 1886

7 AGE Years 41 Months 9 Days 17 If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Servant

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Balto. (State or country) \_\_\_\_\_

10 NAME OF FATHER Fredrick Campbell

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Harriet Ramsey

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

14 Informant Hattie Campbell (Address) 537 Dolphin St.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/1928

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1927, to Mar 25, 1928, that I last saw him alive on Mar. 24, 1928, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

Uremia

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) John H. Thompson, M. D. (Address) 1012 N. Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial \_\_\_\_\_

UNDERTAKER George P. A. Gibson ADDRESS 17352

Filed APR 27 1928

Registrar \_\_\_\_\_

32133

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 32133

### 1-PLACE OF DEATH

TY OF BALTIMORE: (NO. *House of Good Shepherd* ST. *19-28* WARD)

### 2-FULL NAME

(a) RESIDENCE NO. *Mount & Collins St* ST. *19-28* WARD

(Usual place of abode) Length of residence in city or town where death occurred *33* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *3/12/1895*  
AGE Years *33* Months *-* Days *14* If LESS than 1 day, hrs or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laundress*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

BIRTHPLACE (city or town) *Md.* (State or country)

10 NAME OF FATHER *John Shom*

11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)

12 MAIDEN NAME OF MOTHER *Do not know*

13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)

14 Informant *House of Good Shepherd* (Address) *Mount & Collins*

15 *Filed MAR 27 1928*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 26<sup>th</sup>* 19 *28*

17 I HEREBY CERTIFY, That I attended deceased from *March 10<sup>th</sup>*, 19 *28*, to *March 26<sup>th</sup>*, 19 *28*.

that I last saw him alive on *March 26<sup>th</sup>*, 19 *28*

and that death occurred, on the date stated above, at *10<sup>00</sup> a m.*

The CAUSE OF DEATH\* was as follows:

*Chronic nephritis*

(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary) *secondary anaemia* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *signs & symptoms*

(Signed) *J. A. Chatard*, M. D.

(Address) *300 W. Calvert St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St. Peter's Cem*

20 UNDERTAKER *J. John J. Foley & Sons*

(Address) *1318 Light*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

46 E 32134

1. PLACE OF DEATH *Baltimore, Md.* REGISTERED NO. *46 E 32134*  
 CITY OF BALTIMORE: (No. *1610 Park Ave.* ST. *14-70* WARD)  
 2. FULL NAME *Grace Winchenden Fisher*  
 (a) RESIDENCE NO. *1610 Park Ave.* ST. WARD  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *64* yrs. *5* mos. *15* ds. (If non-resident give city or town and State)  
 How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 10 - 1863*

7 AGE Years *64* Months *5* Days *15* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-25* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan.* 19*27*, to *3-25* 19*28*.

that I last saw her alive on *3-25* 19*28*.

and that death occurred, on the date stated above, at *6:30 P. m.*

The CAUSE OF DEATH\* was as follows:

*CARCINOMA OF UTERUS*

(duration) *2* yrs. *+* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *12-16*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. L. S. Smailey* M. D.

, 19 (Address) *1127 St. Paul St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Greenmount Cemetery*

*Mar 27 1928*

20 UNDERTAKER

ADDRESS

*John B. Spence 1325 N. Caroline*

E 37135

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32135

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 707 Josephine St. 1876 Ward)2-FULL NAME Rachel Powell(a) RESIDENCE NO. 707 Josephine St. 1876 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female Negro Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Moses Powell

6 DATE OF BIRTH (month, day, and year)

Feb 6 - 1854

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

74 1 19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, au-topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute dilatation of heart

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) James M. D. M. D.

(Coroner)

, 19 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial

National Cem 3/27 1928

20 UNDERTAKER

Wm. Carter ADDRESS 916  
Be me

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32136

## CERTIFICATE OF DEATH.

31

E 32136

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 243 S. Poppleton

18-29  
Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula Avery(a) RESIDENCE NO. 243 S. Poppleton

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

Negro

5 Single, Married, Widowed,  
or Divorced, (write the word)  
Married6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Charles Avery

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

At home

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

N. C.

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

N. C.

12 MAIDEN NAME OF MOTHER Susie Arlis

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

N. C.

14

Informant

Charles Avery

(Address) 243 N. Poppleton St.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

192

March 25 - 28.

17

I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
inquiry find that said deceased came to her death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Pneumonic Tuberculosis

(duration) ..... yrs. 1 mos. .... ds.

CONTRIBUTORY  
(Secondary)

(duration) ..... yrs. .... mos. .... ds.

(Signed)

(Coroner)

3/26, 1928. (Address) 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death..... yrs. .... mos. .... ds. State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR Date of Burial

REMOVAL

Nalagh H. O.

3/27 1928

20 UNDERTAKER

ADDRESS

916  
Da ar

AR 27 1928

-Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32137

## CERTIFICATE OF DEATH.

E 32137

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *9 Reddy St*)2-FULL NAME *Cent. Joseph J. Jones*(a) RESIDENCE NO. *9 Reddy*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ST.,

WARD

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male*4 COLOR *Col*5 Single, Married, Widowed, or Divorced, (write the word) *no*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *3/25/28*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *no*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *James Jones*11 BIRTHPLACE OF FATHER (city or town) (State or country) *MD*12 MAIDEN NAME OF MOTHER *Emma Thompson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *MD*

14

Informant (Address) *Superior Jones 9 Reddy St*

15

Filed, 19 *28*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/26/28*

17

I HEREBY CERTIFY That I attended deceased from *3/25/28* to *3/26/28*that I last saw him alive on *3/26/28*and that death occurred, on the date stated above, at *2 P* m.

The CAUSE OF DEATH\* was as follows:

*Cardiac Insufficiency*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Stephen D. Davis M.D.*, 19 *28* (Address) *1117 22nd St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Aulem Bur**3-27-28*

20 UNDERTAKER

ADDRESS

*Edward Carter 9 W*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32138

## CERTIFICATE OF DEATH.

E 32138

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2425 E. Monument ST., 7-10 WARD)

## 2-FULL NAME

Frederick Wm. Uhl

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

2425 E. Monument ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteSingleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Dec. 16<sup>th</sup> 1913

## AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.1438

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Balto Md.

## 10 NAME OF FATHER

John Wm Uhl11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Balto Md.

## 12 MAIDEN NAME OF MOTHER

Marie A. Rabbe13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Balto Md.

## 14

Informant  
(Address)John Wm Uhl  
2425 E. Monument St

## 15

Filed

10

Wm. J. [unclear]  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 24<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from

, 19 24, to Mar. 24, 19 28,that I last saw him alive on Mar. 24, 19 28,and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH\* was as follows:

Dis. Sarcoma of Spinal Cord.(duration) 4 yrs. — mos. — ds.CONTRIBUTORY  
(Secondary)(duration) — yrs. — mos. — ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Operation few years ago.(Signed) Dr. H. [unclear] M. D., 19 — (Address) 2352 Entaw Place.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Balto Cem.

DATE OF BURIAL

3/27 1928

20 UNDERTAKER

Philip [unclear]

ADDRESS

Charmist

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32139

## CERTIFICATE OF DEATH.

129 32139

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2242 E. Hoffman ST.; 8-16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George William PlummerResidence in Baltimore: No. 2242 E. Hoffman St.; 55 yrs., — mos., — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX. Male 4-COLOR OR RACE, White 5-STATUS, Married  
(Write the word.)DATE OF BIRTH, Sept. 22, 1863  
(Month) (Day) (Year)AGE, 64 yrs., 6 mos., 4 ds. If LESS than 1 day, — hrs. or — min.OCCUPATION:  
(a) Trade, profession, or particular kind of work, Night Watchman  
(b) General nature of industry, business, or establishment in which employed (or employer) —BIRTHPLACE, (State or Country), EnglandPARENTS. 10-NAME OF FATHER, Edward Plummer11-BIRTHPLACE OF FATHER (State or Country), Lincolnshire England12-MAIDEN NAME OF MOTHER, Elizabeth Dewey13-BIRTHPLACE OF MOTHER (State or Country), Leicestershire England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. J. Plummer  
(Address) 539 N. Fulton Ave.

15-

MAR 27 1928

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 26, 1928.  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct 3<sup>rd</sup> 1927, to Mar 26<sup>th</sup> 1928, that I saw him alive on Mar 22<sup>nd</sup> 1928, and that death occurred, on the date stated above, at 8:30 a.m.The CAUSE OF DEATH\* was as follows:  
Chronic Valvular Heart Disease(Duration) 1 1/2 yrs., 7 mos., — ds.CONTRIBUTORY Chronic nephritis  
(Secondary)(Duration) 8 yrs., — mos., — ds.(Signed) E. J. Plummer M. D.Mar 26, 1928 (Address) 539 N. Fulton Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.Where was disease contracted, if not at place of death? —Former or usual residence —19-PLACE OF BURIAL OR REMOVAL, BaltimoreDATE OF BURIAL, 3/29, 192820-UNDERTAKER, Philip HenryADDRESS 2016 Orleans

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32140

## CERTIFICATE OF DEATH.

E 32140

1-PLACE OF DEATH

503 Robert St

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST., WARD)

2-FULL NAME

Cora Dawson

(a) RESIDENCE NO.

503 Robert St

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1 yr.

mos.

ds.

How long in U. S., if of foreign birth?

yr.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

Colored

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lewis J. Dawson

6 DATE OF BIRTH (month, day, and year)

1895

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mid

12 MAIDEN NAME OF MOTHER

Martha Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mid

14

Informant (Address)

Lewis J. Dawson 503 Robert St

15

MAR 27 1928

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24 1928

17

I HEREBY CERTIFY, That I attended deceased from

2-27 1928 to 3-24 1928

that I last saw her alive on 3-23 1928

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:

Pleurisy & Effusion Myocardial Infarction

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

W. B. Bullock M. D.

, 19 (Address)

4207 E. Endline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Greenwood Cemetery

3/27 1928

UNDERTAKER

ADDRESS

Samuel H. Hensley, 1134 E. Endline St

32141

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *751* *Dalepark* St. *17-24* Ward)2-FULL NAME *Mrs. Lizzie Smith*(a) RESIDENCE NO. *751* *Dalepark* St. *17-24* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *Not known* yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO. 32141

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 Color or Race *Colored*5 Single, Married, Widowed, or Divorced, (write the word) *widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *George Smith*6 DATE OF BIRTH (month, day, and year) *1862*

7 AGE

Years *66*

Months

Days

IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Domestic*(b) General nature of industry, business, or establishment in which employed (or employer) *House work*

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *Va.*10 NAME OF FATHER *Not known*

11 BIRTHPLACE OF FATHER (City or town)

(State or country) *Not known*12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Not known*

14

Informant (Address) *Mrs. Annie Rice*

15 Filed

19

Registrar *[Signature]*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 24* 19*28*

19

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 22* 19*28*, to *Mar. 24* 19*28*,that I last saw him alive on *Mar. 21* 19*28*,and that death occurred, on the date stated above, at *3* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of bladder*  
(duration) *61* yrs. mos. ds.CONTRIBUTORY (Secondary) *Renal*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Examination of body*(Signed) *[Signature]* M. D., 19 (Address) *751 Dalepark*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *St. Anthony's*Date of Burial *3/27*20 UNDERTAKER *[Signature]*ADDRESS *[Signature]*

very important. See instructions



**E 32142**

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓  
**E 32142**  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 Hamburg, 21-29 Ward)

2-FULL NAME Frederick Bury

(a) RESIDENCE NO. 1118 Hamburg

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) April 6<sup>th</sup>, 1890

7 AGE Years 37 Months 11 Days 18 IF LESS than 1 day...hrs. or...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Le Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer Joe. Bury, (Father)

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Joseph Bury

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Fullison

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Joe. Bury (Address) 1118 Hamburg

15 Filed 1928 19 11/11 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24, 1928

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928 to Mar 24, 1928, that I last saw him alive on March 20, 1928, and that death occurred, on the date stated above, at 1245 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Tuberculosis  
Pulmonary

(duration) Ann yrs. 9 mos. ds.

CONTRIBUTORY Cardiac Disturbance (Secondary)

(duration) Ann yrs. Ann mos. ds.

18 Where was disease contracted

If not at place of death \_\_\_\_\_

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) T.M. Kempson, M. D.

, 19 3409 Callaway (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt. Olivet (Cem) Mar 27, 1928

20 UNDERTAKER ADDRESS Liston P. Fussellbaugh 2620 St Paul

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32143

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

2-FULL NAME James Green(a) RESIDENCE No. 1182 Kensington ST., \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred 19 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

EX 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) Sept 1879  
AGE 48 Years \_\_\_\_\_ Months 6 Days \_\_\_\_\_

If LESS than 1 day, \_\_\_\_\_ hrs or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Suburban

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) Baltimore  
(State or country) Md.10 NAME OF FATHER John W. Green11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country)

14

Informant \_\_\_\_\_  
(Address) Reverend

AR 27 1928

Filed

Per

Registrar

REGISTERED NO. 101-001  
E 32143

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 2-4 WARD \_\_\_\_\_

WARD \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/192817 I HEREBY CERTIFY, That I attended deceased from Mar. 21, 1928, to Mar. 24, 1928  
that I last saw him alive on Mar. 24, 1928  
and that death occurred, on the date stated above, at 7:00 P. M.  
The CAUSE OF DEATH\* was as follows:  
Suburban pneumonia(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? yesWhat test confirmed diagnosis? General & Sub.  
(Signed) C. J. Williams M. D.  
, 19 \_\_\_\_\_ (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL St. BarnabasDATE OF BURIAL 3/27/192820 UNDERTAKER J. J. MoranADDRESS 3000 E. Baltimore

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 32144**

## CERTIFICATE OF DEATH.

74-001  
E 32144

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 516-11. Belmont)

2-FULL NAME William Key

(a) RESIDENCE No. 516-11. Belmont  
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds.

ST. 19-27 WARD

REGISTERED NO. 74-001  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 19-27 WARD 19-27  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE negro 5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elynn Bell Key

DATE OF BIRTH (month, day, and year) Mar. 2, 1884  
AGE Years 43 Months 4 Days 22  
If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work John R. Business  
(b) General nature of industry, business, or establishment in which employed (or employer) 045  
(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Madison, Va.

10 NAME OF FATHER John Key

11 BIRTHPLACE OF FATHER (city or town) (State or country) Madison, Va.

12 MAIDEN NAME OF MOTHER Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Madison, Va.

14 Informant (Address) May for pin. 516 11 Belmont

15 Filed 19 REGISTRAR JONES, T. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1928

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1928 to March 23, 1928, that I last saw him alive on March 23, 1928, and that death occurred, on the date stated above, at 12304 m.  
The CAUSE OF DEATH\* was as follows:  
Cerebral Palsy

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 5

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical exam

(Signed) W. A. Jones M. D.  
, 19 (Address) 16 New Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT Guburn Cem DATE OF BURIAL Mar 28 1928

20 UNDERTAKER A. Jones ADDRESS 116 S. Gwyn

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1850 Eagle St

2-FULL NAME

Pearl Burell

(a) RESIDENCE NO.

1850 Eagle St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.,

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

F.

4 COLOR OR RACE

Negro

5 Single, Married, Widowed,

or Divorced, (write the word)

Married

a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Alexander Burell

DATE OF BIRTH (month, day, and year)

July 1892

AGE

Years

Months

Days

If LESS than

1 day, hrs

or min.

35 8

?

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER

Samuel Mhenson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Howard CO. Md.

12 MAIDEN NAME OF MOTHER

Grace Fosette

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Carroll Co. Md.

14

Informant  
(Address)Rosie Wilkens (Sister)  
1846 Eagle St

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 28

17

I HEREBY CERTIFY, That I attended deceased from March 19th. to March 25 28

that I last saw her alive on March 24th. 19 28

and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH\* was as follows:

Annolexy

(duration)

yrs.

mos.

ds.

7

CONTRIBUTORY  
(Secondary)

Unknown

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed)

Walter J. Jackson M. D.

, 19

(Address)

1631 W. Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Auburn Cem Md 28 19 28

20 UNDERTAKER

ADDRESS

A. Jones

1151 Edue



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32146  
PLACE OF DEATH

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

CITY OF BALTIMORE: (No. 814 Hanover ST. 22-31 WARD)

2-FULL NAME Baby Girl White (twin) 1.

(a) RESIDENCE NO. 814 Hanover

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female

Black

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

March 26, 1928

AGE

Years

Months

Days

If LESS than  
1 day, 4 hrs.  
or 0 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

None

(c) Name of employer

None

BIRTHPLACE (city or town)  
(State or country)Baltimore,  
Maryland

10 NAME OF FATHER

Isaac White

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Franklin,  
Virginia

12 MAIDEN NAME OF MOTHER

Odelle Chandless

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Franklin,  
Virginia

14

Informant  
(Address)

Mother

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 26, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
March 26, 1928, to March 26, 1928, at 4:30 A.M.

that I last saw her alive on March 26, 1928,

and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed)

M. Alexander Hovey, M.D.

19

(Address) 1516 Madison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32147

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

814 Hanover ST. 22-31 WARD)

## 2. FULL NAME

Baby Girl White (twin) 2.

(a) RESIDENCE NO.

814 Hanover ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

March 26, 1928

AGE

Years

Months

Days

If LESS than  
1 day, 6 hrs.  
or 0 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Baltimore,  
Maryland

10 NAME OF FATHER

Isaac White

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Franklin,  
Virginia

12 MAIDEN NAME OF MOTHER

Helen Chaudress

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Franklin,  
Virginia

14

Informant  
(Address)

Mother

15

DATE

MAR 27 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 26 1928

17

I HEREBY CERTIFY, That I attended deceased from  
March 26 3:00 P.M. 1928 to March 26 11:30 A.M. 1928

that I last saw her alive on March 26 1928

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. Alexander Kovey M. D.

, 19 (Address) 1516 Madison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Mt Zion Ct

Mar 27 1928

20 UNDERTAKER

ADDRESS

Chas. Brown &amp; Son

108 W. Bond St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32148

## CERTIFICATE OF DEATH

101-001  
E 32148  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Provident Hospital* St. *89* Ward)2-FULL NAME *Martha Blow*(a) RESIDENCE NO. *127 N. Dallas* St.  Ward 

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs.  mos.  ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Virginia Blow*6 DATE OF BIRTH (month, day, and year) *unknown*7 AGE *32* Years Months Days IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *VA*  
(State or country)10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (City or town) *unknown*  
(State or country)12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) *unknown*  
(State or country)14 Informant *William Jackson*  
(Address) *127 N. Dallas*15 Filed *1927* 19 *1927*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 25 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar. 21, 1928* to *Mar. 25, 1928* that I last saw *her* alive on *Mar. 25, 1928* and that death occurred, on the date stated above, at *4:12 P. M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(duration) *Uncertain* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Unknown*Did an operation precede death? *No* Date of Was there an autopsy? *No*What test confirmed diagnosis? *Physical Sign*(Signed) *John W. Gaines, M. D.*(Address) *Provident Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

*Mt. Zion St. Mar. 28 1928*  
*S. H. Brown & Son 100 W. North*

## E 32149 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57E 32149

## 1. PLACE OF DEATH

Baltimore City Hospitals

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John McGinnis

(a) RESIDENCE NO. 852 S. Broadway

(Usual place of abode)

Length of residence in city or town where death occurred Unknown

ST. WARD

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1895

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
33				

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Ireland

10 NAME OF FATHER James McGinnis

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER Mary King

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ireland

14

Informant  
(Address)

Hospital Records

AR 27 1928

Regist

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1928

17 I HEREBY CERTIFY, That I attended deceased from  
March 10, 1928 to March 23, 1928that I last saw him alive on March 23, 1928  
and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH was as follows:

Total Pneumonia

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

18 Where was disease contracted  
(duration) yrs. mos. ds.  
If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical  
(Signed) L. J. Maddox, M. D.  
3-23-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Stanislaus.

DATE OF BURIAL

Mar. 27, 1928.

20 UNDERTAKER

M. J. Sadowicki

ADDRESS

1705 S. Am Dr



32150

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32150

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 New St. ST. 17-25 WARD)2-FULL NAME Estelle Rose(a) RESIDENCE NO. 411 New

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred 47 yrs. mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female4 COLOR OR RACE Robert5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced HUSBAND of (or) WIFE of Edward RoseDATE OF BIRTH (month, day, and year) 11/21/1878

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic(b) General nature of industry, business, or establishment in which employed (or employer) Private(c) Name of employer UnknownBIRTHPLACE (city or town) Baltimore, Md.  
(State or country)10 NAME OF FATHER Johnson Fames11 BIRTHPLACE OF FATHER (city or town) Balt., Md.  
(State or country)12 MAIDEN NAME OF MOTHER Elizabeth13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.  
(State or country)

14

Informant Mary E. Jones  
(Address) 411 New St.

MAR 27 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/28

17

I HEREBY CERTIFY, That I attended deceased from 3/13/28, 1928, to 3/27/28, 1928, that I last saw him alive on 3/27/28, 1928, and that death occurred, on the date stated above, at 3:30 p.m.  
The CAUSE OF DEATH\* was as follows:  
Suppurative  
Throat

(duration)

yr.

mos.

ds.

CONTRIBUTORY (Secondary) Unknown

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? N.Y. CityDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? PhysicianSigned H. Lee Ellis, M. D.(Address) 924 W. 17th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. CalvaryDATE OF BURIAL Mar. 28, 192820 UNDERTAKER Mrs. R. G. ElbertADDRESS 1725

32151

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32151

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1817 Baker* ST. *15-21* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Lula May Hatton*(a) RESIDENCE NO. *1817 Baker*

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred *Life* yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**white**Married*

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Geo. C. Hatton*DATE OF BIRTH (month, day, and year) *Feb. 16-1877*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*51**1**10*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House-wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Balto Md*10 NAME OF FATHER *Elisha Booker*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Md*12 MAIDEN NAME OF MOTHER *Mary E. Quill*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Pa*

14

Informant  
(Address)*Geo. C. Hatton  
1817 Baker St*

15

Filed

AR 27 1928

*C. H. HARRISON, JR.,  
Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 26 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Sept 16*, 19 *27*, to *Mar 26*, 19 *28*.that I last saw him alive on *Mar 26*, 19 *28*and that death occurred, on the date stated above, at *12<sup>50</sup> p m*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*

(duration)

*4* yrs.

mos

ds.

CONTRIBUTORY  
(Secondary)

(duration)

*8* yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death? *✓*Did an operation precede death? *No*Date of *✓*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical Methods*

(Signed)

*George C. Shannon*, M. D.*3/26 1928* (Address)*700 Fulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Loudon Park Cem.**Mar. 28 1928*

20 UNDERTAKER

ADDRESS

*Harry W. Ehlen**1744 W. North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32152

## CERTIFICATE OF DEATH.

E 32152

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

21-29  
ST. WARD)

2-FULL NAME

Patrick O'Brien

(a) RESIDENCE NO.

923 Mc Henry St

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Jan 18 - 1883

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

45

2

7

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Ireland

10 NAME OF FATHER

Patrick O'Brien

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Jane Blaney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant  
(Address)Muddy O'Brien  
923 Mc Henry St

15

Filed

1928

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19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

J. J. Bowman &amp; Son

401 Hollings

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25 1928

17

I HEREBY CERTIFY, That I attended deceased from

3-23, 1928, to 3-25, 1928,

that I last saw him alive on 3-25, 1928,

and that death occurred, on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH\* was as follows:

Perforated Abdominal Ulcer

(duration) yrs. mos. 2 1/2 ds.

CONTRIBUTORY  
(Secondary)

Terminal broncho-pneumonia

(duration) yrs. mos. 1 hr.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of 3-23-28

Was there an autopsy? No

What test confirmed diagnosis? Clinical &amp; operative

(Signed) John Roberts Phillips, M. D.

, 19 (Address) University Hospital

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

HEALTH DEPARTMENT—CITY OF BALTIMORE  
32153 E 32153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2145 W. Balt. ST. WARD) 70-69

2-FULL NAME Allen Elliott Goldstein

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 2145 W. Balt. ST. WARD \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single  
If married, widowed, or divorced HUSBAND of \_\_\_\_\_ or WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) May 18, 1911  
AGE Years 16 Months 10 Days 8 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) Balt. (State or country) Md.

10 NAME OF FATHER Morris Goldstein

11 BIRTHPLACE OF FATHER (city or town) Balt. (State or country) Md.

12 MAIDEN NAME OF MOTHER Ray Gardner

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country) \_\_\_\_\_

14 Informant Mrs. Ray Gardner (Address) 2145 W. Balt. ST.

15 1928 Registered \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/ 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar 24th, 1928 to Mar 26th, 1928.  
that I last saw him alive on Mar. 26th, 1928,  
and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:  
Broncho-pneumonia

(duration) \_\_\_\_\_ yrs. mos. 7 ds.  
CONTRIBUTORY (Secondary) \_\_\_\_\_  
(duration) \_\_\_\_\_ yrs. mos. ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_  
(Signed) Morris Goldstein, M. D.  
3/26, 1928 (Address) 1816 W. North Av.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Balt. Hebrew Cem. DATE OF BURIAL 3/27/ 1928  
ADDRESS 118 20 W. Mt. Royal Ave.

20 UNDERTAKER David Goldstein



32154

## HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 32154

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Riviera Apt. - 113 St. 13-54* Ward)2-FULL NAME *Benjamin Rothschild*(a) RESIDENCE NO. *Riviera Apt. 113 St.* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *32* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Frances Rothschild*6 DATE OF BIRTH (month, day, and year) *Nov. 18, 1861*7 AGE Years *66* Months *11* Days *9* IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired Umbrella*(b) General nature of industry, business, or establishment in which employed (or employer) *Mayer*

(c) Name of employer

9 BIRTHPLACE (city or town) *Cincinnati* (State or country) *Ohio*10 NAME OF FATHER *Abraham Rothschild*11 BIRTHPLACE OF FATHER (City or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Hena Spicker*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Mr. David Weinberg* (Address) *Temple Garden Apt.*15 *7 1928* 16 REGISTRAR *W. J. Jones*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/27/1928*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 1928*, to *March 27, 1928*, that I last saw him alive on *March 27, 1928*and that death occurred, on the date stated above, at *4 A.M.*

The CAUSE OF DEATH\* was as follows:

*Arterio-sclerotic myocarditis*CONTRIBUTORY *uremia* (duration) *5* yrs. mos. da.

(Secondary)

(duration) yrs. mos. da. *10*

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *clinical*(Signed) *7 Frederick L. B. M. D.*Date *3/27/1928* (Address) *Temple Garden Apt.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Hebrew Friendship*Date of Burial *3/29/1928*20 UNDERTAKER *David Londonheim*ADDRESS *113 St. W. No. Royal Ave.*

32155

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

84 E 32155

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 E. 33rd ST., 9-47 WARD)2. FULL NAME Mary Elizabeth Enright(a) RESIDENCE NO. 660 E. 33rd

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ST. 9-47 WARD 9-47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 15-1927

AGE

Years 1Months 1Days 11

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Thos L. Enright11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore12 MAIDEN NAME OF MOTHER Eda T. Ruckle13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14

Informant (Address) Thos L. Enright

7 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1928

17

I HEREBY CERTIFY, That I attended deceased from 9/20/27 19 to 3/26/28 19 that I last saw her alive on 3/26/28 19 and that death occurred, on the date stated above, at 9 P. ni.

The CAUSE OF DEATH\* was as follows:

Acute Dilatation Heart

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None of acute dilatation(Signed) Walter Bacon M.D.(Address) 1025 2nd St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER Wm. F. EvansADDRESS 118 W. Royal Ave.

32156

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32156

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

1928

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/1928

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1928, to March 25, 1928, that I last saw him alive on March 25, 1928, and that death occurred, on the date stated above, at 14, m. The CAUSE OF DEATH\* was as follows:

Malnutrition

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. 6 mos. ds.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. R. Goldberger, M. D. 19 (Address) 2922 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

32157

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 32157

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

TY OF BALTIMORE: (No.

ST. 26-37 WARD)

## 2-FULL NAME

Frank I Nemec

## (a) RESIDENCE NO.

(Usual place of abode)

ST. 26-37 WARD

Length of residence in city or town where death occurred 21 yrs. mos. ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

EX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

1928

SAMSON JOHNS

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1928

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1928, to March 27, 1928, that I last saw him alive on March 27, 1928, and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Lobar Pneumonia

CONTRIBUTORY (Secondary) Chronic Pulmonary Tuberculosis

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris J. Schenck, M. D.

, 19 (Address) 4514 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



E 32158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 32158

1-PLACE OF DEATH

City of BALTIMORE: (No. 2206 Boston St. 1-1 Ward)

2-FULL NAME

Charles Andrew Bangert

(a) RESIDENCE NO.

2206 Buren

(Usual place of abode)

St. 1-1 Ward

Length of residence in city or town where death occurred 60 yrs. 5 mos. 3 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Barbara Bangert

6 DATE OF BIRTH (month, day, and year)

Oct 1-1867

7 AGE

Years

60

Months

5

Days

25

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Restaurant Keeper

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md

10 NAME OF FATHER

Jeff Bangert

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not known

14

Informant (Address)

Mrs Barbara Bangert

15

Filed 1928 Mar 28 19

CHAS. J. B. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 26

1928

17

I HEREBY CERTIFY, That I attended deceased from

3-18

1928

3/26

1928

that I last saw him alive on

3/25

1928

and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH\* was as follows:

Cardiac Asthma

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Acute Pulmonary Edema

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death?..... Date of.....

Was there an autopsy?

What test confirmed diagnosis?

Signed) Edward J. Boor M. D.  
3/26 1928 (Address) 415 Pennsylvania

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer

Mar 30 1928

20 UNDERTAKER

ADDRESS

Thos. G. Coe & Son

1400 N. Howard

32159

HEALTH DEPARTMENT—CITY OF BALTIMORE

32159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429 Winchester St.)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 1429 Winchester St.

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

JOHNS HOPKINS HOSPITAL

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

7 1928 C. HAMMOND JONES, M. D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

March 22, 1928, to March 26, 1928,

that I last saw him live on March 24, 1928,

and that death occurred, on the date stated above, at 6:10 a. m.

The CAUSE OF DEATH\* was as follows:

Bronchot Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. D. Ball, M. D.

19 (Address) 46 E 3rd St Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32160

## CERTIFICATE OF DEATH.

E 32160

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 885 Howard 11-24 Ward)

2-FULL NAME John J. Gorman

(a) RESIDENCE NO. 885 N. Howard St. 11-24 Ward

(Usual place of abode) Length of residence in city or town where death occurred 74 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 74 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) June 27<sup>th</sup> 1852

7 AGE Years 70 Months 8 Days 3 IF LESS than 1 day.....hrs. or.....min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer Ireland

9 BIRTHPLACE (city or town) Ireland  
(State or country)

10 NAME OF FATHER John Gorman

11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Gorman

13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)

14 Informant Michael J. Gorman  
(Address) 19 N. Fremont

15 7 1928 CLAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1928

17 I HEREBY CERTIFY, That I attended deceased from March 23<sup>rd</sup> 1928 to March 24<sup>th</sup> 1928, that I last saw him alive on March 24<sup>th</sup> 1928, and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH\* was as follows:  
Uræmic Coma

(duration) .....yrs. ....mos. ....ds.  
CONTRIBUTORY Intermittent Nephritis  
(Secondary) Arteriosclerosis  
(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted  
if not at place of death? No  
Did an operation precede death? No Date of \_\_\_\_\_  
Was there an autopsy? No  
What test confirmed diagnosis? Clinical  
(Signed) J. J. Saunders, M. D.  
376. 1928 (Address) 219 E. Preston

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 3/28, 1928

20 UNDERTAKER Henry W. Mears Son 805 N. Calvert

935-0  
32161

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32161

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL*ST. *10-14*

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

*Glady - Worden*

## (a) RESIDENCE NO.

*1006 Sterling*

ST.

WARD

*City*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*female*

4 COLOR OR RACE

*black*

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

*1-15-28*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*2**7*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Ind -*

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

## 12 MAIDEN NAME OF MOTHER

*Servia Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)*Records*

7-1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/22/28*

17

I HEREBY CERTIFY, That I attended deceased from  
*March 22, 1928, to March 22, 1928.*that I last saw her alive on *March 22, 1928.*and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Congenital syphilis - early.*(duration) yrs. *1* mos. ds.CONTRIBUTORY  
(Secondary)*Pneumonia - early, moderate**questionable*(duration) yrs. mos. *1* ds.

18 Where was disease contracted

if not at place of death? *at home*Did an operation precede death? *No* Date ofWas there an autopsy? *State Anatomical*

What test confirmed diagnosis?

*Wassermann*

(Signed)

*J. C. Goodrum*

M. D.

19

(Address)

*Johns Hopkins Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



2162

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32162

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *Johns Hopkins Hospital*)

ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Betty Thompson*

## (a) RESIDENCE NO.

*1913 N. Chapel St.*

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male Black*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## DATE OF BIRTH (month, day, and year)

*Mar. 21, 1928*

AGE

Years

Months

Days

If LESS than  
1 day, 5 hrs.  
or 30 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

## 10 NAME OF FATHER

*Columbus Thompson*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

## 12 MAIDEN NAME OF MOTHER

*Mary Sanford*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

7-1928 C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Mar. 21 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*3-21-28* to *3-21-28*that I last saw him alive on *3-21-28*  
and that death occurred, on the date stated above, at *7:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Pruritus*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *C. Hampton Jones*, M. D.3-26-1928 (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

32163

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32163

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OF RACE *Black* 5 Single, Married, Widowed, or Divorced, (write the word) *Unknown*

If married, widowed, or divorced HUSBAND of or WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

7-1928

C. HAMPSON JONES, M. D.

Registrar

20 UNDERTAKER

Commissioner of Health

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-21-28*

17

I HEREBY CERTIFY, That I attended deceased from *7-30-27* to *3-21-28*that I last saw him alive on *3-21-28*and that death occurred, on the date stated above, at *10. J.P. in.*

The CAUSE OF DEATH\* was as follows:

*General Paralysis of Insane*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Unknown*Did an operation precede death? *NO* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

ADDRESS

MAR 27 1928

2164

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32164

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL 27-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Jones(a) RESIDENCE NO. 800 William ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds.

?

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female white

widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of ?

DATE OF BIRTH (month, day, and year) ?

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

80

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Wm. D. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14

Informant

(Address) Records

15

7-1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22/1928

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 5, 1927, to Mar. 22, 1928.that I last saw her live on Mar. 22, 1928and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. mos. 8 ds.

CONTRIBUTORY

(Secondary)

Myocarditis, chronic

yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General + Sals(Signed) C. Hampson Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Interred in

4/7/28

OF BALTIMORE CITY HOSPITAL

UNDER TAKER

ADDRESS

Interred inCOLUMBIAN HOSPITAL

MAR 27 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32165

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD) 10-14

2. FULL NAME Eleanor Cooper(a) RESIDENCE No. 811 Madison ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX \_\_\_\_\_ 4 COLOR OR RACE white colored 5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced HUSBAND of \_\_\_\_\_ (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) \_\_\_\_\_

AGE Years Months Days If LESS than 1 day, hrs. or min. 32

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland10 NAME OF FATHER James Jones11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Julia Cook13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)

14

Informant (Address) Records

15

7-1928

19

P.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/1928

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1928 to March 23, 1928 that I last saw him alive on March 23, 1928 and that death occurred, on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH\* was as follows:

Subar pneumonia(duration) yrs. mos. ds. 4CONTRIBUTORY alcoholism acute  
(Secondary) a chronic

(duration) yrs. mos. ds.

18 Where was disease contracted? ?  
if not at place of death?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? General + Sub(Signed) C. Thompson Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Asbury cemetery 27 1928  
Edward Bryan 1691 Orleans St



32166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 32166

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto. City Hospi. St. Ward 2-4)

2-FULL NAME Filip Juzelewski

(a) RESIDENCE NO. 1821 Bank St. St. Ward St.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

53

8

July

1874

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Labor

9 BIRTHPLACE (city or town)

(State or country)

Poland

10 NAME OF FATHER

Juzelewski

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

14

Informant (Address)

Adamina

Groszkowska

2202

Cambridge

St.

7 1928

19 HAMPSON JONES, M.D. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 24 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds.

(Signed)

(duration)

yrs. mos. ds.

(Address)

(Coroner)

M. D.

19

(Address)

143 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy

Rosary

Cem.

March 27

20 UNDERTAKER

ADDRESS

John M. Weber 401 S. Chester

HEALTH DEPARTMENT—CITY OF BALTIMORE

32167

CERTIFICATE OF DEATH.

101 E 32167

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital 7-13 Ward)

2-FULL NAME Mary Maynes

(a) RESIDENCE NO. 1127 N. Caroline St.        Ward       

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Maynes

6 DATE OF BIRTH (month, day, and year) Oct 20/1868

7 AGE Years 59 Months 5 Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.  
(State or country)

10 NAME OF FATHER Hart

11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)

14 Informant son  
(Address)

7-1928 C. HAMPSON JONES, M. D. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds. CONTRIBUTORY Myocarditis (Secondary)

(Signed) [Signature] M. D. (Coroner)

3/27/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Presbyterian Burial 3/28/28

20 UNDERTAKER L. E. Moran ADDRESS 3000

32168

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32168

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3013 Westwood Avenue

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida May Johannes

(a) RESIDENCE NO. 3013 Westwood Avenue

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Charles Johannes

DATE OF BIRTH (month, day, and year) Feb. 1868

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

60

1

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

At home

9 BIRTHPLACE (city or town) Baltimore

(State or country)

Maryland

10 NAME OF FATHER

George T. Childs

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

Maryland

12 MAIDEN NAME OF MOTHER

Harriet A. Degaw

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

Maryland

14

Informant  
(Address)

Mrs. Harriet A. Irving

Carney Md.

15

27 1928

C. HAMPSON JONES, M. D.  
Per Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March, 25 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 15, 1928 to March 25, 1928.

that I last saw him alive on March 25, 1928.

and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic valvular heart disease

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. Palmer

M. D.

3/26, 1928 (Address) 3005 West North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park

DATE OF BURIAL

Mar. 27 1928

ADDRESS

1003 1/2 Baltimore

20 UNDERTAKER

J. H. Palmer

32169

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32169

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3003 Frederick Ave. ST. 70-70 WARD)

2-FULL NAME Josephine Bomberger

(a) RESIDENCE NO. 3003 Frederick Ave.

(Usual place of abode)

Length of residence in city or town where death occurred Life.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

George C. Bomberger

DATE OF BIRTH (month, day, and year) Aug. 19, 1848

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

7

7

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

Maryland

10 NAME OF FATHER Jos. T. Richards

11 BIRTHPLACE OF FATHER (city or town) Princess

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Princess Anne, Md.

(State or country)

14 Informant Mr. Samuel T. Richards

(Address)

1223 W. Baltimore St.

15 C. HAMPSON JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26 1928

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to Mar 26, 1928, that I last saw him alive on Mar 26, 1928, and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis  
Hypertension  
Myocarditis  
(duration) Unknown

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/26/28 (Address) 2151 Wilkens Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western Cemetery

Mar. 28 1928

20 UNDERTAKER

ADDRESS

1003 West Baltimore St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

32170

49 E 32170

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2420 Harlem Ave. 16-68. Ward)

2-FULL NAME William Magee

(a) RESIDENCE NO. 2420 Harlem Ave. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO.

Length of residence in city or town where death occurred 62 yrs. 2 mos. 9 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 62 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Emma S. Magee (or) WIFE

6 DATE OF BIRTH (month, day, and year) Jan 17 1866

7 AGE Years 62 Months 2 Days 9 IF LESS than 1 day...hrs. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

10 NAME OF FATHER Patterson Magee

11 BIRTHPLACE OF FATHER (City or town) unk known (State or country)

12 MAIDEN NAME OF MOTHER Mary J. Boyd

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs Emma S. Magee (Address) 2420 Harlem Ave

15 Filed C. HAMFSON JONES, M. D. Registrar 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1928, to Mar 26, 1928, that I last saw him alive on Mar 25, 1928, and that death occurred, on the date stated above, at 9 40 a.m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D. 1928 (Address) 735 N. Fulton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Woodlawn Cemetery Mar 28 1928 fosfoerdens O Don 2178. Penn

HEALTH DEPARTMENT—CITY OF BALTIMORE

32171

CERTIFICATE OF DEATH.

197 E 32171

1-PLACE OF DEATH

City of BALTIMORE: (No. *Front of 305 S Eden St.* Ward *3-5*)

2-FULL NAME *Charles F. Gorschboth*

(a) RESIDENCE NO. *326 S Eden* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*

6 DATE OF BIRTH (month, day, and year) *July 14, 1898*

7 AGE Years *36* Months *8* Days *17* IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Stone Mason*  
(b) General nature of industry, business, or establishment in which employed (or employer) *086*  
(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *Baltimore Md.*

10 NAME OF FATHER *Henry Gorschboth*

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Maria Koch*

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) *Germany*

14 Informant *Ida Gorschboth*  
(Address) *326 S Eden St*

15 REGISTRAR *C. HAMMON JONES, M. D.*  
*apb* Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 25 1928*

17 I HEREBY CERTIFY that I took charge of the remains *Autopsy* and an *Autopsy* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Autopsy* and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH was as follows: *Homicide*  
*Gun Shot Wound*

(duration) yrs. mos. ds. *8*  
CONTRIBUTORY (Secondary) *St. Lock*

(duration) yrs. mos. ds. *Mar 25 1928*  
Signed *G. L. B. B. B.* M. D.  
(Address) *143 B Bway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Baltimore* Date of Burial *March 27 1928*

20 UNDERTAKER *Wendell J. Lippel* ADDRESS *310 S Eden St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32172

## CERTIFICATE OF DEATH

179 E 32172

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 417 S. Spring St. 3-4 Ward)

## 2-FULL NAME

Edward Dixon

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

417 S. Spring St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male. Colored

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

## 6 DATE OF BIRTH (month, day, and year)

October 28, 1877

## 7 AGE

50 Years

Months

27 Days

IF LESS than

1 day hrs.

or min.

57.

46 26

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Laborer

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town)

Washington, D. C.

(State or country)

## 10 NAME OF FATHER

George Dixon

## 11 BIRTHPLACE OF FATHER (city or town)

Maryland

(State or country)

## 12 MAIDEN NAME OF MOTHER

Annita Brown

## 13 BIRTHPLACE OF MOTHER (city or town)

Washington, D. C.

(State or country)

## 14

Informant (Address)

Catharine J. Halliday  
417 S. Spring St.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 26, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

1-25-1928, to 3-26-1928.

that I last saw him alive on 3-24-1928.

and that death occurred, on the date stated above, at 3:05 P. M.

The CAUSE OF DEATH\* was as follows:

Valvulitis

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. C. Leuzier, M. D.

3-27-1928 (Address) 611 N. Caroline

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Ashbury Cemetery

March 27, 1928

## 20 UNDERTAKER

Wendell J. Hoppel

310 S. Calvert

7<sup>5</sup> 1928

C. HAMPTON JONES, M. D.

Registrar

E 32173

HEALTH DEPARTMENT—CITY OF BALTIMORE

32173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

DATE OF BIRTH.

AGE,

If LESS than 1 day.

OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed 1928

C. HAMPSON JONES, M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from Jan 1. 1928, to March 25 1928, that I saw her alive on March 23 1928, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH\* was as follows:

Gastric carcinoma

CONTRIBUTORY (Secondary)

(Signed)

Mar 26 1928 (Address) 1211 Mulberry St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS



2174

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32174

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *W.S. Marine Hosp #12-51* ST. *12-51* WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *4* mos.

ds. How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
 1 day, hrs.  
 or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

File *27-1928*

*C. HAMPSON JONES, M. D.*  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
*Dec. 6, 1927*, to *March 24, 1928*,  
 that I last saw him alive on *March 24, 1928*,  
 and that death occurred, on the date stated above, at *3:00 P. m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of pylorus  
 of stomach*

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3-24-1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

UNDERTAKER

DATE OF BURIAL

ADDRESS

*St. Mary's, Hampden*  
*E. Leroy Stiffler*

*March 28, 1928*  
*125 E. North Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32175

CERTIFICATE OF DEATH.

167-001  
E 32175

1-PLACE OF DEATH

City of BALTIMORE: (No. 3205 Glenn Ave St. 14-27 Ward 7)

2-FULL NAME

Charles J. Jagner

(a) RESIDENCE NO.

1602 Edmonson St. Ward       

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1900

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Auto Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Va.

(State or country)

10 NAME OF FATHER

Joel J. Jagner

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Armie Culpeper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va.

14

Informant (Address)

John A. Jagner  
1602 Edmonson St.

15

Reg.

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/21

1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.)

And that said deceased came to this death

on the day stated above.

The CAUSE OF DEATH was as follows:

Gunshot  
Suicide

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) John A. Jagner M. D.

(Address) 5632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St Mary Hospital

Mar 28 1928

20 UNDERTAKER

ADDRESS

Ede Roy Stippeler 1259 North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32176

## CERTIFICATE OF DEATH.

31 E 32176

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2939 E Monument

ST. 711 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Louise Buhner

(a) RESIDENCE No. 2939 E Monument

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

(If married, widowed, or divorced)

HUSBAND of

(or) WIFE of

August C. Buhner

DATE OF BIRTH (month, day, and year) April 13 1869

AGE Years Months 11 Days 13 If LESS than 1 day, hrs or min.

58

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Mr Lupert

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant August C. Buhner

(Address) 2939 E Monument St.

15

7-1928 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26<sup>th</sup> 28

17

I HEREBY CERTIFY That I attended deceased from Dec. 23, 1927, to March 26, 1928.

that I last saw her alive on March 24, 1928.

and that death occurred, on the date stated above, at 6:45 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

CONTRIBUTORY (duration) 6 yrs. 6 mos. ds. Acute dilatation of heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. J. Kibbey, M. D.

3/27, 1928 (Address) 701 N. Kenwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Parkwood, cem March 29 1928

20 UNDERTAKER

ADDRESS

John C. Miller 2735 E Oliver St.

*Deca*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

32177

179 B 32177

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

*Siva's Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.)

ST. *76-1* WARD)

2-FULL NAME

*Michael Deca*(a) RESIDENCE NO. *1002 S Clinton*

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *16* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE *41* Years Months Days If LESS than 1 day, ... hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Labor*

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Poland*10 NAME OF FATHER *August Deca*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Poland*12 MAIDEN NAME OF MOTHER *Antonette Poleniak*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Poland*

14

Informant  
(Address)*Mary Deca**1002 S Clinton St.*

15

7-1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-17 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*3-17 1928*, to *3-27 1928*that I last saw him alive on *3-27 1928*and that death occurred, on the date stated above, at *3:00 PM*

The CAUSE OF DEATH\* was as follows:

*Chronic nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed)

, 19 (Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Stanislaus March 28*

20 UNDERTAKER

ADDRESS

*John M. Weber 401 S. Chester*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32178

## CERTIFICATE OF DEATH.

E 32178

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hosp. 12-49* ST. *12-49* WARD)2. FULL NAME *Mrs. Mildred Scott*(a) RESIDENCE NO. *Harlington Maryland, C*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *2*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*Sept 7 1886**41 years**6**20*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Nurse*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*W. H. Scott*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Florie Hopkins*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Maryland*

14

Informant (Address)

*Sister*

15

1928

G. HAMPSON JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 27 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 8 1927* to *March 27 1928*that I last saw her alive on *March 27 1928*and that death occurred, on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis - With Myocardial infarction - mitral stenosis**9 months*

(duration) yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*Chronic Passing Angina*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*?*

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Physiologist Examination*

(Signed)

*Frank Parker M.D.*

, 19

(Address)

*Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*Harlington Cern, March 29, 1928*

20 UNDERTAKER

ADDRESS

*H. S. Bailey Harlington, Md.*

E 32179

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32179

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 7-12 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Floretta Rada

## (a) RESIDENCE NO.

729 N. Patterson Pk. WARD One

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 2 mos. 8 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

(If married, widowed, or divorced HUSBAND of (or) WIFE of)

## DATE OF BIRTH (month, day, and year)

1-21-28

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8

5

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Ind -

## 10 NAME OF FATHER

Anthony Rada

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind -

## 12 MAIDEN NAME OF MOTHER

Hilda Rada

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind -

14

Informant (Address)

Records -

15

FEDERAL

28 1928

HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar - 26 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb - 26, 1928, to Mar - 26, 1928, that I last saw her alive on Mar - 26, 1928, and that death occurred, on the date stated above, at 10<sup>00</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. 2 mos. ds.

## CONTRIBUTORY (Secondary)

Otitis media

(duration) yrs. mos. 10 ds.

## 18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed)

J. J. Bennett

M. D.

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

## DATE OF BURIAL

Mar. 28 1928

## ADDRESS

## 20 UNDERTAKER

Frank Crachoson

1866 Ashland Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32180

## CERTIFICATE OF DEATH.

E 32180

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1613 North Ave.*)ST. *17* WARD2-FULL NAME *John T. Durham, Sr.*

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

(a) RESIDENCE No. *1613 North Ave.*  
(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred *3* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed,  
or Divorced, (write the word) *Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Mary E. Durham*DATE OF BIRTH (month, day, and year) *March 8-1856*

AGE

Years *72*Months *—*Days *17*If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work *Coal Dealer*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) *Maryland*10 NAME OF FATHER *Parker Durham*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Margaret Parker*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Unknown*

14

Informant  
(Address) *Mrs. Mary E. Durham*  
*1613 North Ave. Mt. Washington*

15

Filed

G. HAMMOND JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 25 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Nov 21, 1925, to Nov. 25, 1925*that I last saw him alive on *Nov 25, 1925*and that death occurred, on the date stated above, at *12:20 p.m.*

The CAUSE OF DEATH\* was as follows:

*Branch pneumonia*(duration) yrs. mos. *7* ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. *2* ds.18 Where was disease contracted  
if not at place of death? ☒Did an operation precede death? ☒

Date of

Was there an autopsy? ☒

What test confirmed diagnosis?

(Signed) *Robert L. Indictel*, M. D.19 *1928* (Address) *2115 Maryland*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Source F. Burpee* *March 28 1928*  
*5631 Falls Rd.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32181

## CERTIFICATE OF DEATH.

31 E 32181

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 Ramsey

ST. WARD)

2. FULL NAME John H Kirby

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1933 Ramsey

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

M

W

S.

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

July 5, 1900

AGE

Years

Months

Day

If LESS than  
1 day, hrs.  
or min.

27

8

21

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer 86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Md.

10 NAME OF FATHER

John H Kirby

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

14

Informant  
(Address)Thomas Ramsey  
1933 Ramsey

15

Filed

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 26, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
March 6, 1928, to March 26, 1928,

that I last saw him alive on March 25, 1928

and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs  
(Signed) W. H. Dipeett, M. D.

19 (Address) 1324 W. Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Industrious Park

DATE OF BURIAL

Mar 28, 1928

20 UNDERTAKER

W. M. Mouton

ADDRESS

2205 N. Mith



32182

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001 E 32182

1-PLACE OF DEATH

2-CITY OF BALTIMORE: (No. 909 N. Fulton Ave 16-22

2-FULL NAME Mary Emmett Ball

(a) RESIDENCE NO. 909 N. Fulton Ave

(Usual place of residence)

Length of residence in city or town where death occurred 82 yrs.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

WARD

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

8 If LESS than 1 day, hrs. or min

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

20 1928

How long in U. S., if of foreign birth?

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration)

yes.

mos.

14 ds.

18 Where was disease contracted if not at place of death?

(duration)

yes.

mos.

ds.

Did an operation precede death?

Date of

What test confirmed diagnosis?

(Signed)

1928 (Address)

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32184

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hosp. 9-47* ST. *WARD*)2. FULL NAME *Mr. Kenneth A. Young (Elizabeth)*(a) RESIDENCE NO. *616 Parkbyth. ave.* ST. *WARD*Length of residence in city or town where death occurred *26* yrs. *7* mos. *21* ds.(If non-resident give city or town and State) *How long in U. S., if of foreign birth? — yrs. — mos. — ds.*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32184

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced HUSBAND or (or) WIFE of *Kenneth A. Young*DATE OF BIRTH (month, day, and year) *August 6, 1901*AGE Years *26* Months *7* Days *21* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife* *037*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Balto. Md.*10 NAME OF FATHER *August Jacobs*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto. Md.*12 MAIDEN NAME OF MOTHER *Cornellia Cook*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto. Md.*14 Informant *Patent or Deceased* (Address)15 Filed *19* *HANSON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 27, 1928*17 I HEREBY CERTIFY, That I attended deceased from *March 26, 1928*, to *March 27, 1928*that I last saw her alive on *March 27, 1928* and that death occurred, on the date stated above, at *3:40 P. M.*The CAUSE OF DEATH\* was as follows: *Acute Cardiac Dilatation*CONTRIBUTORY (Secondary) *12 hours Pulmonary Edema* *12 hours* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical Examination*(Signed) *Frank Taylor M.D.*, 19 (Address) *Union Memorial Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *London Park Crem.* DATE OF BURIAL *3/30, 1928*20 UNDERTAKER *Henry U. Mears & Son* ADDRESS *805 N. Calvert*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32185

## CERTIFICATE OF DEATH.

129 E 32185

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4303 Ethland Ave ST. 15-62 WARD)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2-FULL NAME Elizabeth Brosius(a) RESIDENCE NO. 3313 Egerton Place ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred 61 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced. (write the word) WidowedIf married, widowed, or divorced HUSBAND of (or) WIFE of George BrosiusDATE OF BIRTH (month, day, and year) Apr. 3 - 1866AGE Years Months Days If LESS than 1 day, hrs. or min. 61 11 23

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country) Md.10 NAME OF FATHER Conrad Walter11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Mary Brosius  
(Address) 3313 Egerton Place15 Filed C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 192817 I HEREBY CERTIFY That I attended deceased from Mar 25, 1928, to Mar 26, 1928.that I last saw him alive on Mar 25, 1928, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was, as follows:

NephrosclerosisCONTRIBUTORY (duration) yrs. mos. 2 ds. Chronic Interstitial Nephritis  
(Secondary)(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Walter F. Horner, M. D.(Address) 340 Garrison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Landon Park

DATE OF BURIAL

3/28 1928

20 UNDERTAKER

ADDRESS

W. J. Dickins Bone Co. North



186

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

2 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

60

Years

Months

Days

If LESS than

1 day, hrs

or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

FILE

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-28 1928

17

I HEREBY CERTIFY, That I attended deceased from

3-26-1928, to

3-28, 19-28

that I last saw him alive on

3-28-28, 19

and that death occurred, on the date stated above, at

5:08 A.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia, Lobar.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Hampford Co., Md

Did an operation precede death?

No Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Frank Paula Morris

M. D.

19

(Address)

Union Memorial Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Emory Cem. Hampford Co. Md

Mar 30, 28

20 UNDERTAKER

ADDRESS

Wm. H. Kuer Sons

North St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32187

## CERTIFICATE OF DEATH.

E 32187

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 Wash. Blvd. ST. 24-29 WARD)

## 2. FULL NAME

(a) RESIDENCE No. 1210 Wash. Blvd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced HUSBAND of (or) WIFE of Ida GilchristDATE OF BIRTH (month, day, and year) Dec. 15, 1855AGE Years 72 Months 8 Days 5 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver(b) General nature of industry, business, or establishment in which employed (or employer) Express Business(c) Name of employer Baltimore Transfer Co.BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER James Gilchrist11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER Flanagan13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland14 Informant Theresa Imhoff (General) (Address) 1036 Edmondson Ave15 AN 28 1928 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 192817 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Mar 25, 1928, that I last saw him alive on Mar 25, 1928, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Ex. Nephritis(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Urine Analysis Etc.(Signed) Thas. Horton, M. D.3/27/28 (Address) 888 St. Lombard St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

George Smith Mar 28 1928

## HEALTH DEPARTMENT - CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32188  
1-PLACE OF DEATH151 ✓  
E 32188  
REGISTERED NO.City of BALTIMORE: (No. Mercy Hospital St. 27-54 Ward)2-FULL NAME Marion H. McCoy

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2200 South Rd St. 9th Ward(Usual place of abode)  
Length of residence in city or town where death occurred 48 yrs. 1 mos. 21 ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb 5<sup>th</sup> 18807 AGE Years 48 Months 1 Days 21 IF LESS than 1 day...hrs. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Md10 NAME OF FATHER James M. Coy11 BIRTHPLACE OF FATHER (City or town)  
(State or country)12 MAIDEN NAME OF MOTHER Americus N. Hancock13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant Henry Stohmeyer  
(Address) South Road Highland Ave15 Filed AR 28 1928 16 JAMESON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/28 1917 I HEREBY CERTIFY, That I attended deceased from 3/24/28 19 to 3/26/28 19 that I last saw him alive on 3/26/28 19 and that death occurred, on the date stated above, at 10<sup>25</sup> m.

The CAUSE OF DEATH\* was as follows:

Acute Disease - Hemorrhagic  
Lar NephritisCONTRIBUTORY (duration) yrs. mos. 3-6 ds.  
(Secondary) Uremia(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical  
(Signed) J. W. Winkler M. D.(Address) Mercy Hospital  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

David Bridge3/28/1928

20 UNDERTAKER

ADDRESS

Mr. Weber, Son 2503 Edmond Ave

Charles F Snow Sr  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32189

CERTIFICATE OF DEATH.

E 32189

1-PLACE OF DEATH

City of BALTIMORE: (No. *State Front St. 9-46*)

2-FULL NAME

(a) RESIDENCE NO. *1730 E. 30*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Charles F Snow Sr  
(Address)

15 Filed

C. HAMMON JONES, M. D.  
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 27, 28* 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Viol. dis. heart*

(duration) .....Yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....Yrs. ....mos. ....ds.

Signed (Coroner)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....Yrs. ....mos. ....ds. In the State.....Yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Snow Hill, Md.*

*Mar 29 1928*

ADDRESS

20 UNDERTAKER

*Rita Weddefield 914 Greenbelt Ave*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32190

## CERTIFICATE OF DEATH

90 E 32190

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 426 Myrtle Ave Ward 7)2-FULL NAME William L. Gagne(a) RESIDENCE NO. 406 Myrtle Ave Ward 7

(Usual place of abode)

Length of residence in city or town where death occurred 1 mos. 1 ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? 1 yrs. 1 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 Color or Race Colored5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of None6 DATE OF BIRTH (month, day, and year) May 88

7 AGE

Years 40Months 10Days 1

IF LESS than 1 day.....hrs. or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public Health(b) General nature of industry, business, or establishment in which employed (or employer) PH

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER Geo. L. Gagne

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Gagne

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address) Betha B. Gagne15 Filed 1928

19

Registrar W. H. Jones

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-1928

17

I HEREBY CERTIFY, That I attended deceased from 3-26-1928, to 3-27-1928.that I last saw him alive on 3-27-1928.and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart DiseasePulmonary Edema(duration) 6 yrs. 6 mos. 1 ds.

CONTRIBUTORY

(Secondary)

Heart (duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) W. H. Jones M. D.27 1928 (Address) 600 W. Arlington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial Mar 30 1928

20 UNDERTAKER

ADDRESS Samuel J. W. Jones

E 32191

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32191

1-PLACE OF DEATH U.S. Marine Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Remington Ave. &amp; Wyman Park Drive WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas L. Dunaway

(a) RESIDENCE No. Merry Point, Va.  
(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct. 20, 1872

AGE Years 55 Months 5 Days 7 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Second Officer

(c) Name of employer S.S. "Harby"

BIRTHPLACE (city or town) Virginia  
(State or country)

NAME OF FATHER Ruben Dunaway

BIRTHPLACE OF FATHER (city or town) Va.  
(State or country)

MAIDEN NAME OF MOTHER Sara Bean

BIRTHPLACE OF MOTHER (city or town) Va.  
(State or country)14 Informant Records, U.S. Marine Hospital  
(Address)

MAR 28 1928 HAMPSON JONES, M. D.

Per

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 19 28

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 19 28, to March 27, 19 28,

that I last saw him alive on March 27, 19 28,

and that death occurred, on the date stated above, at 8:40 A.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of the stomach

(duration) one yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem examination

(Signed) S. J. Hall, M. D.

, 19 (Address) U.S. Marine Hospital, Balto.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

32192

CERTIFICATE OF DEATH.

61-100 E 32192

1-PLACE OF DEATH

City of BALTIMORE: (No. 707 E Monument Ward 74)

2-FULL NAME Christina Spear

(a) RESIDENCE NO. 707 E Monument Ward 74

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. 17 ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race Red 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 8-1928

7 AGE Years Months Days 17 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Mar 27-1928

10 NAME OF FATHER Louise Spear

11 BIRTHPLACE OF FATHER (city or town) S. C. (State or country)

12 MAIDEN NAME OF MOTHER Mary Heath

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mary Heath (Address) 707 E Monument

15 1928 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Malnutrition

(duration) 7 month child CONTRIBUTORY (Secondary)

(Signed) F. B. Jones M. D.

(Address) 1010 Ave D

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Comptroller Health

ADDRESS

MAR 28 1928

32193

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 32193

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 S. Chester ST. 1-3 WARD)

### 2-FULL NAME

(a) RESIDENCE NO. 21 S. Chester ST. 1-3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) M

If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia Garrett

DATE OF BIRTH (month, day, and year) Jan 12-1853

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 75 2 14

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coffin

(b) General nature of industry, business, or establishment in which employed (or employer) Tug Boat

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Cal

10 NAME OF FATHER John Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cal

12 MAIDEN NAME OF MOTHER Mary Blaine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cal

14

Informant (Address) Regenia Garrett

15

8 1928

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 12 1928 to Mar 26 1928, that I last saw him alive on Mar 26 1928

and that death occurred, on the date stated above, at 6:00 m.

The CAUSE OF DEATH\* was as follows:

Central Hemorrhage

(duration) yrs. mos. ds. 14

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of Mar 26 1928

Was there an autopsy? ✓

What test confirmed diagnosis? Physical signs

(Signed) Lockwood M. D.

(Address) 1937 Gough St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

MOVAL Heath Memorial

20 UNDERTAKER J. L. Moran

DATE OF BURIAL

3/29 1928

ADDRESS E. B. Adams



32194

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32194

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 16-37 WARD)2-FULL NAME Frida Horton(a) RESIDENCE NO. 218 S. St.

(Usual place of abode)

Length of residence in city or town where death occurred 1 mos.

ST.,

WARD

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced HUSBAND of (or) WIFE of Louis HortonDATE OF BIRTH (month, day, and year) May 10 - 1890

AGE

37

Years

Months

Days

If LESS than 1 day, hrs. or min.

1016

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) md  
(State or country)10 NAME OF FATHER Lawrence Krotke11 BIRTHPLACE OF FATHER (city or town) md  
(State or country)12 MAIDEN NAME OF MOTHER Catharine13 BIRTHPLACE OF MOTHER (city or town) md  
(State or country)

14

Informant  
(Address)

15

Filed 1928

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16 19 28

17

I HEREBY CERTIFY, That I attended deceased from 3-16, 19 28, to 3-16, 19 28.that I last saw him live on 3-16, 19 28.and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH\* was as follows:

Myocarditis, acute

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? autopsy(Signed) C. J. Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Zion Cemetery, St. Michaels Run3/30 19 28

20 UNDERTAKER

ADDRESS

George W. Ziskler1737 E. Eager St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32195

CERTIFICATE OF DEATH.

101-204 E 32195

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 1-3 Ward)

2-FULL NAME Jacob F. Kappel

(a) RESIDENCE NO. 805 S. Montford St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year)

July 25-1914

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

13

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work as School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

10 NAME OF FATHER Milton Kappel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine Nicholas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore.

14

Informant Catherine Kappel

(Address) 805 S. Montford an

15 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said Inquiry find that said deceased came to this death on the day stated above.

18 CAUSE OF DEATH was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

Cholera (duration) 1 yrs. 1 mos. 1 ds.

2878 (Address) 143 B Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

First Evang Cemetery

20 UNDERTAKER

George W. Zinkler

Date of Burial

3/29 1928

ADDRESS

737 E. Egan St

32196

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 32196

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3315 Hudson

ST. 26-1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Miller

(a) RESIDENCE No. 3315 Hudson  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

John Miller

DATE OF BIRTH (month, day, and year) Dec 26-1871

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

56

3

-

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Not known

14

Informant  
(Address)John Miller  
3315 Hudson St

15

1928

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1928

17

I HEREBY CERTIFY, That I attended deceased from 3-25-28, 19, to 3-26-28, 1928, that I last saw her alive on 3-26-28, 1928, and that death occurred, on the date stated above, at 12:35 P. M.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis -

Cardio-vascular-renal

Hypertension  
Sclerosis  
Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Mild insufficiency -  
(duration) 1 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Phy exam -

(Signed) Louis F. Gurnea, M. D.

19 (Address) 722 N. Kenwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oaklawn Cemetery

DATE OF BURIAL

3/29 1928

20 UNDERTAKER

George W. Zirkler

ADDRESS

1737 E. Egan St





## HEALTH DEPARTMENT—CITY OF BALTIMORE

2198

## CERTIFICATE OF DEATH.

E 32198

## -PLACE OF DEATH

Y OF BALTIMORE: (No

-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

married, widowed, or divorced  
HUSBAND of  
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

8-1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Mar. 26, 1928, to Mar. 27, 1928.

that I last saw her alive on Mar. 26, 1928.

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. W. Kauder M. D.

3-27-28 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32199

## CERTIFICATE OF DEATH.

90 E 32199

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2722 St Paul ST. 12-50 WARD)

2. FULL NAME Harry Kinnamon Muller

(a) RESIDENCE No. 2722 St Paul ST., 12 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 76 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? 76 yrs. 10 mos. 5 ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced  
HUSBAND of Alice Muller  
(or) WIFE of

DATE OF BIRTH (month, day, and year) May-21-1851

AGE Years 76 Months 10 Days 5 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Treasurer of Board

(b) General nature of industry, business, or establishment in which employed (or employer) of Beneficence

(c) Name of employer of the M. P. Church

BIRTHPLACE (city or town) Balto. (State or country) Md.

10 NAME OF FATHER Louis Muller

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Eulocia Hills

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Miss Edna H. Muller (daughter) (Address) 2722 St. Paul St. City

15 8 1928 19 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1928

17

I HEREBY CERTIFY, That I attended deceased from July 7-1925 to March 26-1928, that I last saw him alive on March 25-1928, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH\* was as follows:

mitral Insufficiency, Cardiac Hypertrophy (Hypertrophy) Cardiac dilatation - (duration) 2 yrs. - mos 26 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Grand Juror M. D.

(Address) 2125 Maryland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery

## 20 UNDERTAKER

Stewart Monument

## DATE OF BURIAL

Mar 29/1928

## ADDRESS

Balto.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32200

## CERTIFICATE OF DEATH.

57 E 32200

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 2018 Presbury St S. 15-2 Ward)

### 2-FULL NAME

Benjamin Marshlin

### (a) RESIDENCE NO.

2018 Presbury St. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

#### SEX

Male

#### 4 Color or Race

White

#### 5 Single, Married, Widowed, or Divorced, (twice the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Bertha Marshlin

#### 6 DATE OF BIRTH (month, day, and year)

March 17<sup>th</sup> 1868

#### 7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

60

10

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 9 BIRTHPLACE (city or town)

(State or country)

England

### 10 NAME OF FATHER

Benj. Marshlin

### 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

### 12 MAIDEN NAME OF MOTHER

Don't know

### 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

England

### 14

Informant (Address)

Bertha Marshlin  
2018 Presbury St

1928 C. HAMPSON JONES

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

19

Mar 27/28

#### 17

I HEREBY CERTIFY, That I attended deceased from

Nov 19, 1920, to Mar. 27, 1928,

that I last saw him alive on Mar 26, 1928,

and that death occurred, on the date stated above, at 4:15 p.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction  
Distal

(duration) over 24 hrs. yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

#### CONTRIBUTORY

(Secondary)

because of heart disease  
to take heart medicine

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

#### 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? Physically

(Signed) Edith Smith, M. D.

325 12<sup>th</sup> (Address) 155 W North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Behar Friendship Cemetery March 30/28

#### 20 UNDERTAKER

ADDRESS

J. Ahrens  
2452 Reisterstown Rd

2207

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32207

## CERTIFICATE OF DEATH.

31  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 Lexington St ST 70-69 WARD)

## 2-FULL NAME

Rose E. Tourne

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2101 Lexington St ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 50 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX— 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)  
Female White MarriedIf married, widowed, or divorced  
HUSBAND of or WIFE of Thomas T. TourneDATE OF BIRTH (month, day, and year) Dec 14/1877  
AGE Years Months Days If LESS than 1 day, hrs. or min.  
50 3 13

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER George Pegelow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katie Werschmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Thomas T. Tourne  
(Address) 2101 Lexington St

15 8 1328 C. HAMPTON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1928

17

I HEREBY CERTIFY, That I attended deceased from 31 2 1928 to 31 27 1928 that I last saw him alive on 31 27 1928 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 11-House

Did an operation precede death? no • Date of

Was there an autopsy? no.

What test confirmed diagnosis? Phys. Examination

(Signed) Jno. T. Jones, M.D.

3/28 1928 (Address) 804 Cathedral Y.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

London Park Cemetery

Mar 30 1928

20 UNDERTAKER

ADDRESS

Harry H. Amason 4201 W. Edgewood Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32204

## CERTIFICATE OF DEATH.

10 E 32204

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4232 Woodlea Ave.)

## 2. FULL NAME

(a) RESIDENCE No. 4232 Woodlea Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 6 ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/28/28

17

I HEREBY CERTIFY, That I attended deceased from

March 24, 1928 to March 28, 1928.

that I last saw her alive on March 28, 1928.

and that death occurred, on the date stated above, at 1:40 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical (Signed) J. S. Harding M. D.

(Address) 4919 Belair Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Druid Ridge Cemetery 10/28/28  
for Saunders & Son 2175 Beech

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST. 7-9 WARD

2-FULL NAME George H. Alton

(a) RESIDENCE NO. 2257 - 13th S. Spitt. Petersburg Fla WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced

HUSBAND of Mary Alice Alton (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 1-1857

AGE Years 70 Months 7 Days 27 If LESS than 1 day, ... hrs. or ... min.

OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Electrical

(c) Name of employer Gen. Elect. Co.

BIRTHPLACE (city or town) Rhode Island (State or country)

10 NAME OF FATHER John Alton

11 BIRTHPLACE OF FATHER (city or town) Providence (State or country) Mass

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Charles (Address) Johns Hopkins Hospital

15 8-1928 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1928

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1928, to March 27, 1928, that I last saw him alive on March 27, 1928, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Benign Prostatic Hypertrophy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical &amp; Autopsy

(Signed) S. A. Jones, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Boston Mass

3/28 1928

20 UNDERTAKER

ADDRESS

Hughes-Jones Inc 444 N 3rd

32204

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32204

## CERTIFICATE OF DEATH.

91-002

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1458 Riverside Ave.* ST. *24-33* WARD)

2-FULL NAME *Adam Laumann*

(a) RESIDENCE NO. *1458 Riverside Ave.* ST. WARD

Length of residence in city or town where death occurred *58* yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

If married, widowed, or divorced, HUSBAND of (or) *Wife* of *Elizabeth Dammacher*

DATE OF BIRTH (month, day, and year) *Dec. 5<sup>th</sup> 1887*

AGE Years *85* Months *3* Days *20* If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Porter - Boss of*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *American Ice Co.*

BIRTHPLACE (city or town) (State or country) *Germany*

10 NAME OF FATHER *Henry Laumann*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

PARENTS

14 Informant (Address) *Mrs. Geo. Gochel 1458 Riverside Ave.*

15 *8* *1928* C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 26<sup>th</sup> 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 27* 1928 to *March 26* 1928, that I last saw him alive on *March 26* 1928, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Arterio Sclerosis*

CONTRIBUTORY (Secondary) (duration) *3* yrs. mos. ds. *Similarity*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *C. J. White* M. D. 3/27, 1928 (Address) *1279 Williams*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*First United German Evangel. Cemetery* DATE OF BURIAL *3/27/1928*

20 UNDERTAKER *C. J. Fanning, Jr. - 1460 Battery Ave.* ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32205

## CERTIFICATE OF DEATH

32205

### 1-PLACE OF DEATH

City of BALTIMORE: (City) 212 East

St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Beamer

(a) RESIDENCE 207 Chesapeake

St. 1 Ward Hagerstown Md

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. 5 mos. 5 ds. How long in U. S. if of foreign birth? yrs. 5 mos. 5 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 Color or Race C 5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unk

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE Years 86 Months 8 Days 2 IF LESS than 1 day... hrs. or... min..

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown MD (State or country)

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (City or town) unk (State or country)

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) unk (State or country)

14 Informant Rev J. C. Jones (Address) 207 Chesapeake

15 1928 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 19 28

17 I HEREBY CERTIFY, That I attended deceased from March 18, 19 28, to March 25, 19 28.

that I last saw her alive on March 25, 19 28

and that death occurred, on the date stated above, at 1 A M.

The CAUSE OF DEATH\* was as follows:

Chronic Dislateral Hypertension  
(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted

if not at place of death? unk

Did an operation precede death? unk Date of unk

Was there an autopsy? unk

What test confirmed diagnosis? unk

(Signed) J. C. Jones M. D.

3-28, 19 28 (Address) 508 Hammond St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown, Md. Date of Burial March 28, 1928

20 UNDERTAKER Fred W Kraiss ADDRESS Hagerstown, Md.



32206

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 90 E 32206

1-PLACE OF DEATH

St. Josephs Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.)

ST. 9-17 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna S. Muhlberg  
Pasadena, Md

(a) RESIDENCE NO.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male White Married

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Albert F. Muhlberg

DATE OF BIRTH (month, day, and year)

Feb. 23<sup>rd</sup> 1892

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

36

1

5

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore Co.

Maryland

10 NAME OF FATHER

Joseph Knott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Susan Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Albert F. Muhlberg  
Pasadena, Md.

15 8-1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 21, 1928, to Mar. 28, 1928, that I last saw him alive on Mar 28, 1928, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Embolus

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman A. Vandy, M. D.

19 (Address) St. Josephs Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Holy Redeemer Cemetery March 31, 1928  
Patrick J. Jones & Son, Baltimore



HEALTH DEPARTMENT—CITY OF BALTIMORE

32208

CERTIFICATE OF DEATH.

E 32208

1-PLACE OF DEATH

City of BALTIMORE: (No. 1407 N. Calhoun Ward 15-23)

2-FULL NAME Annie P. Wilkerson

(a) RESIDENCE NO. 1407 N. Calhoun Ward 15-23

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of Adam Wilkerson (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 25-1882

AGE Years 45 Months 9 Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Camden, N. J. (State or country)

10 NAME OF FATHER Robert Thomas

11 BIRTHPLACE OF FATHER (city or town) Ida (State or country)

12 MAIDEN NAME OF MOTHER Wilkerson

13 BIRTHPLACE OF MOTHER (city or town) Ida (State or country)

14 Informant Adam Wilkerson (Address) 1407 N. Calhoun

28 1928 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fracture of Ear and Head (duration) 3 mos. ds.

CONTRIBUTORY (Secondary) G. B. Link (duration) 3 yrs. mos. ds.

(Signed) Coroner M. D.

(Address) North Ave & Drive

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

PLACE OF BURIAL, CREMATION OR REMOVAL North Ave & Drive Date of Burial 12/28

20 UNDERTAKER Thomas G. Nelson ADDRESS 1303

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32209

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. *St. Josephs Hospital* ST. *9-17* WARD)FULL NAME *Caroline Russ*RESIDENCE NO. *Leviston Pa.* ST.  WARD 

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 *Single* Married, Widowed, or Divorced, (write the word)*female**White**Married*married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Ralph Russ*DATE OF BIRTH (month, day, and year) *Feb 29 - 1878*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*50**27*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Italy*

10 NAME OF FATHER

*Francis Saverio*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Italy*

12 MAIDEN NAME OF MOTHER

*Theresa Masi*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Italy*Informant  
(Address)*Ralph Russ*  
*Leviston Pa.*

8 1928

C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/28/28* 19

17

I HEREBY CERTIFY, That I attended deceased from  
*3/25/28*, 19, to *3/28/28*, 19,  
that I last saw her alive on *3/28/28*, 19,  
and that death occurred, on the date stated above, at *2:45 P. m.*  
The CAUSE OF DEATH\* was as follows:*cardio-vascular-renal*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*James G. Vont*

M. D.

, 19 (Address)

*St. Josephs Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
BURIAL*Leviston Pa*

DATE OF BURIAL

*3/29 1928*

20 UNDERTAKER

*Robert Brooks & Son*

ADDRESS

*Calverton*  
*Holmdel Rd*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32210

## CERTIFICATE OF DEATH.

E 32210

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *709 N. Monroe* ST. *16-22* WARD)2-FULL NAME *Anna Louise Green*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *709 N. Monroe* ST. *16-22* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6 married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *Feb 24 1860*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER *Andrew C. Green*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Annella T. Green*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)*Edw. J. Jones, M. D.*

MAR 29 1928

HARRISON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 28 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Dec 11**1927*

to

*March 28**1928*

that I last saw him alive on

*March 28**1928*

and that death occurred, on the date stated above, at

*12 A. M.*

The CAUSE OF DEATH\* was as follows:

*Calcification of Stomach, 600.  
Secondary Anemia.*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *E. J. Jones*

M. D.

19

(Address) *806 N. Fulton St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

32211

E 32211

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32211

PLACE OF DEATH

OF BALTIMORE: (No.

FULL NAME

RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 10 mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 COLOR OR RACE 2 Sex 3 Single, Married, Widowed, or Divorced (write the word)

4 married, widowed, or divorced HUSBAND of (or) WIFE of

5 DATE OF BIRTH (month, day, year) 6 AGE Years Months Days If LESS than 1 day, hrs or min

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

R 79 1928

HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from March 25, 1928, to March 28, 1928, that I last saw him alive on March 27, 1928, and that death occurred, on the date stated above, at 12:58 p.m. The CAUSE OF DEATH\* was as follows: Myocardial

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

32212 HEALTH DEPARTMENT—CITY OF BALTIMORE

32212

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

Y OF BALTIMORE: (No.

192 Oakdale Road, St. 27-53 WARD)

2-FULL NAME

Randolph Keech Wright Jr.

(a) RESIDENCE NO.

192 Oakdale Road

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

-- yrs. 1

mos. 24

ds.

How long in U. S., if of foreign birth?

-- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Feb. 3, 1928

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

--

1

24

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore

Maryland

10 NAME OF FATHER Randolph K. Wright

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

Maryland

12 MAIDEN NAME OF MOTHER Elise Caldwell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

Maryland

14

Informant

Randolph K. Wright

(Address)

192 Oakdale Road

15

Filed

HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/28 19

17

I HEREBY CERTIFY, That I attended deceased from

Jan 24, 19 8, to Mar 27, 19 28.

that I last saw him alive on March 27, 19 28.

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Trace of Haemorrhage

(Signed)

Walter C. Bacon, M. D.

(Address)

1002 20th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Henry U. Meers, Son 805 N. Calvert





## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH *St. Agnes Hospital*

Y OF BALTIMORE: (No. \_\_\_\_\_)

ST. *20-69* WARD)REGISTERED NO. *49 E 32214*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Cora Sowers*(a) RESIDENCE No. *2111 Frederick Ave.* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. — mos. — ds.

How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*If married, widowed, or divorced HUSBAND of (or) WIFE of *Archy Sowers*DATE OF BIRTH (month, day, and year) *June 29th 1884*AGE Years *43* Months *8* Days *28* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Va.*10 NAME OF FATHER *no given*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va.*12 MAIDEN NAME OF MOTHER *Va.*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va.*

14

Informant (Address) *Archy Sowers*

MAR 29 1928

JAMES JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-28 1928*

17

I HEREBY CERTIFY, That I attended deceased from *2-15* 1928, to *3-28* 1928,that I last saw her alive on *3-28* 1928, and that death occurred, on the date stated above, at *3:45* a. m.

The CAUSE OF DEATH\* was as follows:

*Lympho-sarcoma of eye.*CONTINUOUS (duration) yrs. *9* mos. ds. *Primary Carcinomatosis*(Secondary) (duration) yrs. *3* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *2/28/28*Was there an autopsy? *No*What test confirmed diagnosis? *Microscopic*(Signed) *Agnes P. Von Schulz, M.D.*(Address) *St. Agnes Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Not Christ Cemetery 3/29/28*

FUNERAL TAKER

*W. H. Nippert, 1850 W. Baiter St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

215

## CERTIFICATE OF DEATH.

90 E 32215

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1447 Henry St. 24-33)

## 2-FULL NAME

John Kensel

## (a) RESIDENCE No.

1447 Henry St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Dallie Richardson

DATE OF BIRTH (month, day, and year)

July 23 1866

AGE

Years

Months

Days

61

5

3

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

House work

(c) Name of employer

B. C. A Steam Ship Co.

BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

George Kensel

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Mrs. Emma Kensel Seymour  
1447 Henry St.

15

Filed

MAR 29 1928

C. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 26 1928

17

I HEREBY CERTIFY, That I attended deceased from

Aug 23 1927 to March 26 1928

that I last saw him alive on March 25 1928

and that death occurred, on the date stated above, at 7:00 A. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) 0 yrs. 8 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1319 Light St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Laudens Park

March 28 1928

20 UNDERTAKER

Chas. L. Stevens

ADDRESS

1501

E. Fort, Md.

HEALTH DEPARTMENT—CITY OF BALTIMORE

32216

CERTIFICATE OF DEATH.

171 E 32216

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 S Bway St. 2-4 Ward)

2-FULL NAME George. Pages

(a) RESIDENCE NO. 715 S Bway St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

7 DATE OF BIRTH (month, day, and year) Dec 1864

AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 63 3 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town)

(State or country) Greece

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) Greece

14 Informant J. Sachtnues  
(Address) 715 S Broadway

15 Filed C. HAMPSON JONES, M. D.  
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said Inquest, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Suicide  
cut Throat  
Shock

CONTRIBUTORY (Secondary) Mar 26 1437 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Woodlawn Cemetery 3/30 1928

20 UNDERTAKEN ADDRESS George J. Ruth 1430 Harford Ave

AR 29 1928

E 32217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1704 Hollins St. Ward 19-28)

2-FULL NAME Elizabeth Reckert

(a) RESIDENCE NO. 1704 Hollins St. Ward 19-28

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 15 1860

AGE Years 67 Months 3 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Sauter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

PARENTS

14

Informant Mrs. Frank Sauter  
(Address) 100 Rosemary Ave  
Hammond

15

Filed....., 19 28  
C. HAMMOND Registrar

E 32217  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest and that said deceased came to Death (by topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed) Chas. B. Norton M. D. 28 1928 (Address) Curtis Bay

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See instructions for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Cemetery March 30 28

20 UNDERTAKER ADDRESS

George J. Rith 1735 Harford Ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32218

## CERTIFICATE OF DEATH.

E 32218

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Chapel Gate Bldg.)

WARD)

## FULL NAME

George Smith Kieffer

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

36 Leeds Ave. - Arbutus

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

20

yrs.

/ mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married.

(If married, widowed, or divorced, HUSBAND of or) WIFE of

Sarah Elizabeth Kieffer

DATE OF BIRTH (month, day, and year)

Sept. 23, 1884

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

83

6

4

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired (5 yrs)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Hagerstown Md.

10 NAME OF FATHER

Moses Kieffer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Catherine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Emmittsburg Md.

14 Informant (Address)

Margaret E. Kieffer 36 Leeds Ave.

15 Filed 1928

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 27, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1927, to March 27, 1928,

that I last saw him alive on March 25, 1928,

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

(duration) 5 mos. ds.

CONTRIBUTORY (Secondary)

Cerebral hemorrhage

(duration) 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest M. Smith, M. D.

(Address) 436 Mayland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem.

Mar 30, 1928

20 UNDERTAKER

ADDRESS

Wm. Kieffer Sons

Novelty Pa.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32219

## CERTIFICATE OF DEATH.

REGISTERED NO.

32219

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3818 Chatham Rd 15-63

ST. WARD)

2-FULL NAME

Frederica D. Pick

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

3818 Chatham Rd

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

64 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of or WIFE of

DATE OF BIRTH (month, day, and year)

Mar 2, 1853

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

0

25

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Clerfield Co. Pa

10 NAME OF FATHER

Edward Pick.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Laura Breunler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address)

Miss Margaret Pick 3818 Chatham Rd.

15

Filed

HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 27, 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1928, to Mar. 27, 1928, that I last saw her alive on Mar 27, 1928, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH\* was as follows:

Cardiac syncope

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

arteriosclerosis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed)

G. L. Pickens

M. D.

3/29, 1928 (Address)

7945 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

London Park Cemetery

Mar 30, 28

20 UNDERTAKER

ADDRESS

Wm. McKee Sons

North Pa

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32220

## CERTIFICATE OF DEATH

57 E 32220  
REGISTERED NO.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. West. Balto - Gen. 141-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred A. Stevens

(a) RESIDENCE NO. 2544 Calverton Heights Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Doyle Stevens

DATE OF BIRTH (month, day, and year) Jan 21, 1855

7 AGE Years 73 Months 2 Days 7 IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work BTO. Employee  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Ohio  
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Margaret D. Stevens  
(Address) 2544 Calverton Heights

15 Filed 29 1928 FRANKSON JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1928

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1928, to March 29, 1928, that I last saw him alive on March 29, 1928, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY (Secondary) Dehydration (duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 da.

Unconscious (duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? \_\_\_\_ Date of \_\_\_\_

Was there an autopsy?

What test confirmed diagnosis? Blod & urine Physical

(Signed) Dr. William Thomas, M. D.

29. 1928 (Address) Med. Auto 1224

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York Ohio Date of Burial Mar 30 1928

20 UNDERTAKER John O. Hutchins

32221

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32221

## PLACE OF DEATH

Y OF BALTIMORE: (No. 1312 W. Lexington ST.

FULL NAME Laura A. Sanders

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

(a) RESIDENCE No. 1312 W. Lexington ST.,  
 (Usual place of abode)

Length of residence in city or town where death occurred

LIFE yrs. mos. ds.

WARD \_\_\_\_\_  
 (If non-resident give city or town and State)  
 How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX \_\_\_\_\_  
 4 COLOR OR RACE \_\_\_\_\_  
 5 Single, Married, Widowed,  
 or Divorced, (write the word)

male White Single  
 married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE \_\_\_\_\_  
 Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
 If LESS than  
 1 day, hrs \_\_\_\_\_  
 or min. \_\_\_\_\_

## OCCUPATION OF DECEASED

(a) Trade, profession or  
 particular kind of work \_\_\_\_\_ Retired

(b) General nature of industry,  
 business, or establishment in  
 which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
 (State or country)

Baltimore, Md.

10 NAME OF FATHER Edward Sanders

11 BIRTHPLACE OF FATHER (city or town)  
 (State or country)

Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
 (State or country)

Maryland

Informant Mrs. Mass

(Address) 1312 W. Lexington St.

15 Filed \_\_\_\_\_ 19 \_\_\_\_\_  
 HAMILTON JONES, M.  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 19 28

17 I HEREBY CERTIFY, That I attended deceased from  
 March 2nd., 19 28, to March 27th., 19 28,  
 that I last saw her alive on March 27th., 19 28,  
 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
 Carcinoma of Liver

(duration) \_\_\_\_\_ yrs. mos. 25 ds. +  
 CONTRIBUTORY Acidosis

(duration) \_\_\_\_\_ yrs. mos. 3 ds.  
 18 Where was disease contracted  
 if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis?

(Signed) *Ed. Revoluter* M. D.

5/28 19 28 (Address) 24 N. Fulton Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
 MOVAL

New-cathedral

UNDERTAKER

J-G-Mitchell & Sons

DATE OF BURIAL

Mar 30 19 28

ADDRESS

1900 Eutaw

Place



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32222

## CERTIFICATE OF DEATH.

E 32222

1-PLACE OF DEATH

2-OF BALTIMORE: No. 131 1/2 Polmae

2-FULL NAME Mrs Mary E Meads

(a) RESIDENCE. No. 131 1/2 Polmae ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

WARD)

WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX male 2 COLOR OR RACE white 3 Single, Married, Widowed, or Divorced (write the word) Widowed

4 If married, widowed, or divorced (or) WIFE of Charles R. Meads

5 DATE OF BIRTH (month, day, and year) May 25 1856

6 AGE 71 Years Months 10 Days 3

7 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER William M. Cord

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary E. McCord

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

R 29 1928

HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 27, 1928, to Mar 28, 1928, that I last saw him alive on Mar 28, 1928, and that death occurred, on the date stated above, at 3:30 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed)

19

(Address) 100 79 Luluwoodly

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park Cem

Mar 31 1928

2818 E. Balto St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32223

1-PLACE OF DEATH

City of BALTIMORE: (No.

300 N. Robinson

6-11 St., Ward)

2-FULL NAME

Anna Minch

(a) RESIDENCE NO.

300 N Robinson

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs.

mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32223

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

If married, widowed, or divorced  
(or) WIFE of

Charles Minch

DATE OF BIRTH (month, day, and year)

April 21-1860

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

67

11

7

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

John Franz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna Jost

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

PARENTS

14

Informant  
(Address)

Mrs. Gertrude Hagemaster

15

Filed

300 N Robinson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 28

19

28

17

I HEREBY CERTIFY, That I attended deceased from

3-26

19

3/28

19

28

that I last saw him alive on

3-28

19

28

and that death occurred, on the date stated above, at

557 P

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

CONTRIBUTORY  
(Secondary)

Cerebral Hemorrhage

(duration) 1 yrs. 3 mos. 3 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cook (M. D.)

(Address) 413 N. Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (Use reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

Oak Lawn Cem

20 UNDERTAKER

Joseph J. Cook

ADDRESS

103 N. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32224

CERTIFICATE OF DEATH

7 ✓  
E 32224  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2644 Harlem Ave 16-68 Ward)

2-FULL NAME Glendell Lee Johnson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2644 Harlem Ave St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

16 DATE OF DEATH (month, day, and year)

19

Male

White

Child

March 28 - 1928

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ☒

17

I HEREBY CERTIFY, That I attended deceased from

March 31, 1928, to March 28, 1928.

that I last saw him alive on March 28, 1928.

and that death occurred, on the date stated above, at 10.20 a m.

6 DATE OF BIRTH (month, day, and year)

Dec. 25 - 1925

The CAUSE OF DEATH\* was as follows:

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

2

3

☒

Broncho pneumonia

(see note)

(duration) yrs. mos. ds.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY (Secondary)

Myocarditis

(duration) yrs. mos. ds.

9 BIRTHPLACE (city or town)

Baltimore Md.

(State or country)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Shannon, M. D.

PARENTS

10 NAME OF FATHER Lorenz Shannon Johnson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore County Md.

12 MAIDEN NAME OF MOTHER Georgia Elizabeth Burr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore County Md.

(Address) 700 N. Fulton Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14

Informant

(Address) Harold A. Swartz  
7925 Thimble Rd

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Bodlewn Cemetery

Mar. 30 1928

20 UNDERTAKER

ADDRESS  
1003 W.  
Baltimore St

15 Filed

1928

19 HANCOCK JONES, M. D. Registrar

Joseph Cook

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32225

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 32225

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 5-8 Ward)2-FULL NAME Willie Wynn(a) RESIDENCE NO. 1305 May St

(Usual place of abode)

St. May Ward 5-8Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

male

col

single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

July 31/27

AGE

Years

Months

Days

7

26

IF LESS than  
1 day.....hrs.  
or.....min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER John Wynn

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Reba Whitney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va.

14

Informant  
(Address)

Mother

15 Filed

C. HANCOCK JONES, M. D.  
1928 Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

192

Mar 26/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-topsy or inquiry.) and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia (Primary)

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner)

M. D.

3/28/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place  
of death.....yrs. ....mos. ....ds.

In the

State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

asbury cemetery

march 28

20 UNDERTAKER

Edward Bryan

ADDRESS 1681  
orleans st



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32226

CERTIFICATE OF DEATH.

X177E 32226

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7-9 Ward)

2-FULL NAME

Susie Carr

(a) RESIDENCE NO. Fort Howard

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced HUSBAND of (or) WIFE of

John J. Carr

DATE OF BIRTH (month, day, and year)

Feb 7/1895

AGE Years 33 Months 1 Days 20 If LESS than 1 day.....hrs. or.....min.

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) Home  
(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Washington D.C.

10 NAME OF FATHER

William Davis

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Kate Campbell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant (Address)

Husband

MAR 29 1928. HAMMOND JONES, M. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Arspenamine Poisoning- Accidental.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) J. L. H. Jones M. D. (Coroner)

3/29/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

National Cem. 3/30 1928. ADDRESS 1723 Latrobe

10 UNDERTAKER

Leo S. Crook

32227

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32227

-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Poplar Grove ST. 16-68 WARD)

2-FULL NAME Margaret Merritt

(a) RESIDENCE No. 1417 Poplar Grove (Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 4 mos. 2 ds.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word) *W* *S.*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Mar 23 65*  
AGE Years Months Days 3 If LESS than 1 day, hrs. or min.  
*62* *4* *2*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House work*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Balto Md.*10 NAME OF FATHER *John P Merritt*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Emma Heritage*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*14 Informant *Mrs B Grant* (Address) *1417 Poplar Grove St.*15 *29 1928* *HAMMON JONES, M. D.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 26 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar 16*, 1928, to *March 26*, 1928, that I last saw her alive on *March 26*, 1928, and that death occurred, on the date stated above, at *7 P. m.*

The CAUSE OF DEATH\* was as follows:

*Dilated Myocardium  
+ Mitral regurgitation*(duration) *5* yrs. — mos. — ds.CONTRIBUTORY (Secondary) *Pulmonary embolism*(duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *M. Baum and Hood*, M. D.*3/27*, 1928 (Address) *626 N. Guilmer St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Balto Cemetery**Mar 28 1928*

20 UNDERTAKER

ADDRESS

*W. M. Montross**223 W. Smith*

32228 Co.—200 Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 32228

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1224 W Lafayette St. 16-23 Ward)2-FULL NAME Annie Bolden(a) RESIDENCE NO. 1224 W Lafayette St. 16-23 Ward  
(Usual place of abode)Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female4 Color or Race Colored5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 18747 AGE 54 Years Months Days

IF LESS than 1 day.....hrs. or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Domestic9 BIRTHPLACE (city or town) Va  
(State or country)10 NAME OF FATHER Richard Moody11 BIRTHPLACE OF FATHER (City or town) Va  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant John Bolden  
(Address) 1224 W Lafayette St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 192817 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1928, to Mar 27, 1928, that I last saw her alive on March 26, 1928, and that death occurred, on the date stated above, at 9 A.M.  
The CAUSE OF DEATH\* was as follows:  
Metastatic Cancer

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. H. Hatcher, M. D.  
3/28, 1928 (Address) 1224 W Lafayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

APR 25 1928

C. HAMILTON JONES, Registrar

Starbury Va 3-20-28  
George H. Gibson  
1738 E. Baltimore

HEALTH DEPARTMENT-CITY OF BALTIMORE

E 32229

E 32229

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Dr. White's Hospital* Ward)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. 3 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE 56 Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

File

16 HAYESON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 28 1928*

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*Cerebral Hemorrhage (Apoplexy)*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *3*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

7 ME 32230

1. ~~32230~~ DEATHCITY OF BALTIMORE: (No. 1003 W. Sanborn St. WARD 15-21)2. FULL NAME Sylvester Pearson, Jr.(a) RESIDENCE NO. 15-27 N. Bruce St. ST. 15 WARD 21

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male4 COLOR OR RACE Col.5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) July 20, 1927

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 8 8

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) (State or country) Baltimore Md.10 NAME OF FATHER Sylvester Pearson11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.12 MAIDEN NAME OF MOTHER Laura Davis13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14

Informant (Address) Sylvester Pearson  
15-27 N. Bruce St.

15

Filed

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28-1928

17

I HEREBY CERTIFY, That I attended deceased from 3-27-1928 to 3-28-1928, that I last saw him alive on 3-27-1928, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

measlesCONTRIBUTORY (Secondary) Branchio-Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1027 N. Bruce St.Did an operation precede death? No

Date of \_\_\_\_\_

Was there an autopsy? NoWhat test confirmed diagnosis? George A. Buge

(Signed)

, 19

(Address) 18 N. Mount St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL 141 N. Auburn

DATE OF BURIAL

3/29/192820 UNDERTAKER Mrs. Geo. H. HollandADDRESS 1631 N. ...

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 32231

## CERTIFICATE OF DEATH

REGISTERED NO.

E 32231

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *405 Lorraine Ave* Ward *2-50*)

## 2-FULL NAME

(a) RESIDENCE NO. *405 Lorraine Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Married*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *M. Olivia Blackburn*

DATE OF BIRTH (month, day, and year)

*Dec 27/1860*

7 AGE

Years

Months

Days *29*IF LESS than  
1 day... hrs.  
or... min..*67**2**30*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Office Manager**Bigelow Bros & Co*

## 9 BIRTHPLACE (city or town)

(State or country)

*Center Co**Pa*

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*John M Blackburn**Pa*

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

*Ruth Smith**Pa*

14

Informant  
(Address)*Mrs. Schuyler C Blackburn*  
*2615 Barclay St*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 26**1928*

17

I HEREBY CERTIFY, That I attended deceased from

*3/20**1928*to *3/26**1928*that I last saw him alive on *3/26**1928*and that death occurred, on the date stated above, at *9:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Acute Lobar Pneumonia*

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*

(Signed)

*3/27 1928*

(Address)

*2020 N. Charles*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

*Lorraine Cemetery**Mar 29 1928**John F. Denny**7152 1/2 St*

MAR 23 1928

JAMES J. JONES, M.D.

2232

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100E 32232

-PLACE OF DEATH

OF BALTIMORE: (No. 225 J Register

ST. 2-4 WARD

-FULL NAME

Mary A Dailey

REGISTERED NO.

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

(Usual place of abode)

225 J Register

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

female

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

Sept 27/1927

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

6

1

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore Md

10 NAME OF FATHER

Robert H Dailey

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Steelton Pa

12 MAIDEN NAME OF MOTHER

Emma A Perkins

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Middle River Md

Informant  
(Address)Mr Robert H Dailey  
225 J Register

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1928

17

I HEREBY CERTIFY, That I attended deceased from  
March 20, 1928, to March 27, 1928,  
that I last saw her alive on March 27, 1928,  
and that death occurred, on the date stated above, at 6 40 a. m.  
The CAUSE OF DEATH\* was as follows:Broncho-Pneumonia  
(duration) yrs. mos. 10 ds.CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed) Frank A. Glantz, M. D.  
1928 (Address) 3244 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-  
MOVAL

Oak Lane

DATE OF BURIAL

Mar 31 1928

20 UNDERTAKER

John F. Denny

ADDRESS

715 1/2 St

32233

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 302 W. Monument ST. 11-15

FULL NAME Paul Skibitzki

a) RESIDENCE NO. 202 W. Monument ST.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. 57 E 32233

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white Married

HUSBAND of (or) WIFE of Louise Skibitzki

DATE OF BIRTH (month, day, and year)

Apr 23, 1861

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66 11 5

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tig Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

Wolff

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Frankfurt Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

Informant (Address)

Louise Skibitzki 202 W. Monument St.

Filed 23 1928

HAMILTON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 28 1928

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1928, to March 28, 1928, that I last saw him alive on March 28, 1928, and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH\* was as follows:

Diabetes mellitus

CONTRIBUTORY (Secondary)

(duration) 10 yrs. 0 mos. 0 ds.

Bronch pneumonia

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Examination.

(Signed) Chas. S. Keistadt, M. D.

19 (Address) 1730 Linden av.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

DATE OF BURIAL

London Park

Mar 30 1928

UNDERTAKER

ADDRESS

Thos. W. John W. Tengel &amp; Son 81 W. Ayell



HEALTH DEPARTMENT—CITY OF BALTIMORE

32234

CERTIFICATE OF DEATH.

E 32234

1-PLACE OF DEATH

City of BALTIMORE: (No. 783 Sarah Ann St. Ward 4-76)

2-FULL NAME Nancy Thomas

(a) RESIDENCE NO. 783 Sarah Ann St. Ward 4-76

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

Negro

Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

John Thomas

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

53

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

John Thomas  
783 Sarah Ann St.

29 1928

C. HAMPSON JONES, M. D.  
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

March 18

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry find that said deceased came to her death her on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Apoplexy

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) Arthur Zeller, M. D.

(Coroner)

3/10, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32235

## CERTIFICATE OF DEATH.

REGISTERED NO. 32235

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 127 Winter St. St. 23-31 Ward)

2-FULL NAME Alexander Mankins.(C)

(a) RESIDENCE NO. 127 Winter St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male.

Colored

Single.

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

March 21, 1928

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

0

0

3

### 6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 7 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

### 10 NAME OF FATHER

James Mankins.(C)

### 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Washington, D. C.

### 12 MAIDEN NAME OF MOTHER

Lucy Thornton.(C)

### 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia.

14

Informant (Address)

Lucy Mankins.(C) mother. 127 Winter St.

15

Filed

G. HAMPSON JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1928 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Mitral Insufficiency congenital.

### CONTRIBUTORY (Secondary)

(Signed)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

(Coroner)

3/26 19 28 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

### 20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT--CITY OF BALTIMORE

32236

## CERTIFICATE OF DEATH

10-00E 32236  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Sydenham Hospital* Ward)2-FULL NAME *Jesse Staten*(a) RESIDENCE NO. *1805 Falls Road*

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred *10* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Colored**Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year)

*Aug 31, 1911*

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

*16**7**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*School*

## 9 BIRTHPLACE (city or town)

(State or country)

*N.C.*

## 10 NAME OF FATHER

*Grey Staten*

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*N.C.*

## 12 MAIDEN NAME OF MOTHER

*Mary Davies*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*N.C.*

14

Informant (Address)

*Mary Staten  
1805 Falls Road*

15

Full

*G. HAMMOND JONES, M.D.  
Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 26, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 24, 1928, to March 26, 1928*that I last saw him alive on *March 26, 1928*and that death occurred, on the data stated above, at *6:45 a.m.*

The CAUSE OF DEATH\* was as follows:

*Nasal Pharyngeal  
Diphtheria*

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary)

*Myocarditis*

(duration) yrs. mos. 2 da.

18 Where was disease contracted

If not at place of death? *Home*Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *Clinical & pos. culture*(Signed) *Myron G. Jones*, M.D.*3/29, 1928* (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

PUBLIC CEMETERY

20 UNDERTAKER

ADDRESS

*Commissioner of Health**MAR 29 1928*

2237

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32237

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hosp.*, ST. *7-4* WARD)2. FULL NAME *Louis di' Stefano*(a) RESIDENCE NO. *5-20 1/2 Washington Blvd.*, WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *male* COLOR OR RACE *Italian* Single, Married, Widowed, or Divorced, (write the word) *Infant*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Mar. 26 '28*AGE Years Months Days *2* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Angelo di Stefano*11 BIRTHPLACE OF FATHER (city or town) *Newport News* (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Mamie Punniello*13 BIRTHPLACE OF MOTHER (city or town) *Louisiana* (State or country)14 Informant *Angelo di Stefano* (Address) *5-20 1/2 Washington Blvd.*15 *CHAMBERLAIN JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 28 1928*17 I HEREBY CERTIFY That I attended deceased from *Mar. 26*, 1928, to *Mar. 28*, 1928, that I last saw him alive on *Mar. 28*, 1928, and that death occurred, on the date stated above, at *9:20* p. m.

The CAUSE OF DEATH\* was as follows:

*Compression of the Brain following Instrumental Delivery* (duration) yrs. mos. ds. *Exhaustion* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *L. P. di Stefano* M. D. (Address) *407 N. Euter St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*JOHN HOPKINS HOSPITAL*

20 UNDERTAKER

*Chamberlain Jones, M. D.*ADDRESS *MAR 29 1928*



32238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 E 32238

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 6-10 Ward)

2-FULL NAME Louise Norman

(a) RESIDENCE NO. 2438 E. Fayette St

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) single

a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) May 25/1923

AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
4 10 3

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Warren Norman

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Elsie Bloodsworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co., Md.

14 Informant Mother (Address) \_\_\_\_\_

9 1928

19

Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

THE CAUSE OF DEATH\* was as follows:

toxemia- Accidental Burns- face body. Pulled kettle of hot water from Stove.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) [Signature] (Coroner) M. D.

3/29/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds. Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Princess Anne Md Date of Burial 3/30/28

20 UNDERTAKER Hughes Jones Inc 44 N 10th

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

32239

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Plan 1. 710 St Paul St. 11-15 Ward)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

St. Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female white

Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

July 14 1904

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

about 23 9 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Reporter for Sun Paper Co

9 BIRTHPLACE (city or town)

(State or country)

Ind.

10 NAME OF FATHER

David Stewart

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Edith Botley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ind.

14

Informant (Address)

W. A. Adams  
129. Taylor

15 1928 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 28 - 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Carbon monoxide poisoning

Found dead in auto. in garage  
(duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

(Signed)

(Coroner)

M. D.

Mar 28 1928 (Address)

1639 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park

Mar 30 1928

20 UNDERTAKER

ADDRESS

Henry H. Jenkins  
129. Taylor

HEALTH DEPARTMENT—CITY OF BALTIMORE

32240

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH  
City of BALTIMORE: (No. 512 W. Preston St. 17-24 Ward)

2-FULL NAME Grant Dryshields

(a) RESIDENCE NO. 512 W. Preston St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 6 mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) (Child)

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 12-1927

AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
6 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Titus Dryshields

11 BIRTHPLACE OF FATHER (city or town) Ind (State or country)

12 MAIDEN NAME OF MOTHER Lucy Bradley

13 BIRTHPLACE OF MOTHER (city or town) Ind (State or country)

14 Informant Lucy Dryshields (Address) 512 W. Preston

15 9-19-28 C. HAMPTON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28th 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

find that said deceased came to death topsy or inquiry.)

on the day stated above.  
The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds. 3

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) F. C. Lusk, M. D. (Coroner)

(Address) North Art & Circum

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

W. A. Lusk 3/30 1928

20 UNDERTAKER L. A. Lusk ADDRESS 96

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32241

E 32241

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

TY OF BALTIMORE: (No. 405 N. Calhoun St.

ST. 14-76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Virginia Chew

(a) RESIDENCE No. 405 N. Calhoun St.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

25 yrs. ? mos. ?

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

William H. Chew

DATE OF BIRTH (month, day, and year)

May 17, 1882

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

4

10

11

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Chas. Co. Md.

10 NAME OF FATHER

Moses Dorsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Chas., Co. Md.

12 MAIDEN NAME OF MOTHER

Mary Queen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Chas. Co. Md.

14

Informant

(Address)

Josephine Davadage (Daughter)

405 N. Calhoun St.

15

Filed

19

G. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 28

17

I HEREBY CERTIFY, That I attended deceased from March 24<sup>th</sup>, 28, to March 28, 1928

that I last saw her alive on March 27, 19

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds. 4

CONTRIBUTORY (Secondary)

Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed)

Walter S. Jackson

M. D.

, 19

(Address)

1631 W. Franklin St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

W. Auburn Ben

3-30-28

D. M. Jackson

8/6 Be ne



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32242

## CERTIFICATE OF DEATH.

198-E 32242

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 125 St. 125 Ward)2-FULL NAME William E Hamilton(a) RESIDENCE NO. 2414 Mace

(Usual place of abode)

St. \_\_\_\_\_

Ward \_\_\_\_\_

Length of residence in city or town where death occurred 8 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MaleColSingle

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

7 DATE OF BIRTH (month, day, and year)

1893

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.35

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md.10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

PARENTS

14

Informant

(Address)

Charles Jackson  
110 E Lexington

15

F. 1928

16 HAMILTON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.)

And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Shot wound through heart & hemorrhage (am.)  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Homaney (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. M. D.

(Address)

3/29, 1928 3632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

National Cem 3/30 192820 UNDERTAKER ADDRESS 916David Cotton De me

32243

(Carter)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32243

## PLACE OF DEATH

Y OF BALTIMORE: (No. *University Hospital* ST. *8-26* WARD)FULL NAME *George Carter*

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

(a) RESIDENCE NO. *227 Kabb Alley* ST. *8-26* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. *0* mos. *0* ds.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE *Col*5 Single, Married, Widowed,  
or Divorced, (write the word) *single*

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) *1890*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work *Director*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) *Baltimore Md*10 NAME OF FATHER *Wm. Moore*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Md*12 MAIDEN NAME OF MOTHER *Wm. Moore*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Md*Informant *Mr. C. Cole*(Address) *227 Kabb Alley*

20 1928

HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/27/28*

17

I HEREBY CERTIFY, That I attended deceased from

*1/13/28*, 19 *28*, to *3/27/28*, 19 *28*,that I last saw him alive on *3/27/28*, 19 *28*,and that death occurred, on the date stated above, at *3:10 A.M.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*  
*pneumococcus septimus*

(duration) yrs. *4* mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. *10* mos. *4* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *strep*(Signed) *J. H. Husky*, M. D., 19 *28* (Address) *Univ Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *St. Andrew's*

DATE OF BURIAL

*3/30/28*20 UNDERTAKER *St. Andrew's*ADDRESS *918*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32244

32244

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1917 Linden Ave* ST. *14* WARD)2. FULL NAME *Ashby, G. L. Nitaffer*(a) RESIDENCE NO. *1917 Linden Ave* ST. *14* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed, Divorced, (write the word) *Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Anna C. Nitaffer*DATE OF BIRTH (month, day, and year) *Feb 22 1868*

AGE

Years *63*Months *1*Days *5*If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Metal Ceiling worker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *self*BIRTHPLACE (city or town)  
(State or country) *Baltimore Md*10 NAME OF FATHER *William Ashby*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Unknown*

14

Informant  
(Address) *Mrs Anna C. Nitaffer*  
*1917 Linden Ave*

15

1028

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 27 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 25*, 19 *28*, to *Mar 27*, 19 *28*.that I last saw him alive on *Mar 27*, 19 *28*.and that death occurred, on the date stated above, at *m.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*(duration) yrs. mos. ds. *2*CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no*

Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Dr. H. H. Rahn*

M. D.

3/28, 1928 (Address) *3002 W. York Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *London Park*

DATE OF BURIAL

*3/30 1928*

ADDRESS

*512 E. State Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

32245

CERTIFICATE OF DEATH.

E 32245

1-PLACE OF DEATH

City of BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, year)

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

7 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filled

16 HALLISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY That I took charge of the remains described above, held an inquest thereon and from the evidence obtained had that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

18 CONTRIBUTORY (Secondary)

19 INTO THE DISEASE CAUSING DEATH, OR IN DEATH FROM NOLENT CAUSES, state (1) Means and Nature of Injury, (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side of this certificate.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Date of Burial

ADDRESS



HEALTH DEPARTMENT—CITY OF BALTIMORE

32246

CERTIFICATE OF DEATH.

REGISTERED NO.

E 32246

1-PLACE OF DEATH

City of BALTIMORE: (No. 3528 Park Heights St. 15 Ward)

2-FULL NAME Mary C. Slonaker

(a) RESIDENCE NO. 3528 Park Heights Ward

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph R. Slonaker

DATE OF BIRTH (month, day, and year) Dec 1, 1859

AGE Years 68 Months 3 Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) MD

10 NAME OF FATHER Henry Roelke

11 BIRTHPLACE OF FATHER (city or town) Germany

12 MAIDEN NAME OF MOTHER Catherine Mumford

13 BIRTHPLACE OF MOTHER (city or town) MD

14 Informant (Address) Joseph R. Slonaker  
3528 Park Heights

1928

RPA

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day dated above.

The CAUSE OF DEATH was as follows:

Epilepsy

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) John Morrison M. D.

(Address) 3632 Roland

3/29 1928

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION, or REMOVAL Hill Cem, Uniontown Date of Burial 3/31 1928

20 UNDERTAKER 7th Coh ADDRESS 512 E North Ave

(Brashears)

HEALTH DEPARTMENT—CITY OF BALTIMORE

32247

CERTIFICATE OF DEATH

E 32247

1-PLACE OF DEATH

City of BALTIMORE: (No. Sydenham Hospital 2-4 Ward)

2-FULL NAME Ellen Brubaker

(a) RESIDENCE NO. 19 S. Castel

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

April 9, 1925

7 AGE

Years

Months

Days

IF LESS than  
1 day. hrs.  
or min.

2

11

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Me.

10 NAME OF FATHER

Joseph K. Brubaker

11 BIRTHPLACE OF FATHER (City or town)

Balt.

(State or country)

Me.

12 MAIDEN NAME OF MOTHER

Marie Kell

13 BIRTHPLACE OF MOTHER (city or town)

Balt.

(State or country)

Me.

14

Informant

(Address)

Mr. Marie Brubaker

19 S. Castel St.

15 Filed

19

RRH

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

March 29, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 18, 1928, to March 29, 1928,

that I last saw her alive on March 29, 1928,

and that death occurred, on the date stated above, at 3:00 p. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 18 ds.

18 Where was disease contracted

If not at place of death? AT Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed)

J. L. Linn

M. D.

3-29, 1928 (Address)

Sydenham Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Oak Lawn

March 30, 1928

20 UNDERTAKER

ADDRESS

Wandell Huppel 37 S. Amos

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32248

E 32248

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2438 Ashland Ave. Ward 20-69)2-FULL NAME Myrtle H. Stanley(a) RESIDENCE NO. 2438 Ashland Ave. Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Edgar Stanley  
2438 Ashland Ave.

9 1928

C. HAMPSON JONES, M. D.  
Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 21

17 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1921, to Mar 29, 1921, that I last saw him alive on Mar 28, 1921, and that death occurred, on the date stated above, at 4:30 pm.

The CAUSE OF DEATH\* was as follows:

Bronchitis PneumoniaCONTRIBUTORY (duration) yrs. mos. ds. (Secondary) Bronchitis Pneumonia

18 Where was disease contracted (duration) yrs. mos. ds.

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar Stanley, M. D.  
3/29, 1921 (Address) 714 N. Pat. Lane

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Baltimore  
Wendell Duppel  
37 Lams

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32249

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

2. CITY OF BALTIMORE: (No. of block)

3. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

29 1926

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Jan. 25, 1928, to Mar. 28, 1928,  
that I last saw him alive on Mar 28, 1928,

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia - Exacerbated Partial  
Bronchial  
Pneumonia -

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. D.

19 (Address) 307 6th St. N. W.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32250

113 E 32250

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

City of BALTIMORE: (No.

1937 Booth

St. 20-28 Ward

2-FULL NAME

Wm. H. Shears

(a) RESIDENCE NO.

1937 Booth

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male Col

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Apr 31<sup>st</sup> 1927

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

10 26

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Infant

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

10 NAME OF FATHER

Edward Shears

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Isabelle Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

Isabella Shears 1937 Booth St

9-1928

C. HAMPTON JONES, M. D.

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 26, 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Infantile Convulsions

CONTRIBUTORY (Secondary)

Intestinal Indigestion

(Signed) Thos. B. Norton M. D.

Mar 28, 1928 (Address)

Curtis Bay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See back of certificate for instructions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial

Auburn Cem Mar 30th 28

20 UNDERTAKER

C. Jones

ADDRESS

111 S. Liberty

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32251

## CERTIFICATE OF DEATH.

E 32251

PLACE OF DEATH

Y OF BALTIMORE: (No. 1 Bon Secours Hospital)

2-FULL NAME James Smith

(a) RESIDENCE No. Mt Washington-Smith Ave

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 27-1928

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Johanna Crowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant

15

30 1928

G. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar. 27, 1928, to Mar. 29, 1928, that I last saw him alive on Mar. 28, 1928, and that death occurred, on the date stated above, at 6:30 A. m. The CAUSE OF DEATH\* was as follows:

Asphyxia, cause unknown sudden.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical

(Signed)

George O. Eaton, M. D.

, 19

(Address)

Bon Secours Hospl.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Mary Cemetery (Dover) Mar. 30 1928

Franklin W. Leitz 707 W. 33rd



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32253

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 622 W. Lexington St., 4-25 Ward)

2-FULL NAME Maud Mobley

(a) RESIDENCE NO. 622 W. Lexington St. 4-25 Ward

(Usual place of abode)  
Length of residence in city or town where death occurred 10 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 32253

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year)

AGE Years 48 Months Days IF LESS than 1 day.....hrs. or.....min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant W. M. Routson (Address) Greene & Saratoga Sts.

15 Filed 18 30 1928 H. A. JONES Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 - 28 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Carbon Monoxide Poisoning.  
Illuminating Gas. Accident?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) August J. Zeller (Coroner) M. D.

3/29 19 28 (Address) 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Hillboro Tex

Mar 30 19 28

20 UNDERTAKER

W M Routson

ADDRESS 2238 N



32254

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

84 E 32254

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4156 Falls Road ST. 13-57 WARD)

## 2-FULL NAME Frank E. Walters

(a) RESIDENCE No. 4156 Falls Road ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

4

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Margaret E. Walters

DATE OF BIRTH (month, day, and year)

May 24-1873

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

54

10

4

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

Pa Ry 073

(c) Name of employer

BIRTHPLACE (city or town, State or country)

Balt Co.

10 NAME OF FATHER

Rob. Walters

11 BIRTHPLACE OF FATHER (city or town, State or country)

Md.

12 MAIDEN NAME OF MOTHER

Emma Gray

13 BIRTHPLACE OF MOTHER (city or town, State or country)

Md.

14

Informant  
(Address)Mrs Margaret E Walters  
4156 Falls Road

15

AR 30 1928

HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/29 1928

17

I HEREBY CERTIFY That I attended deceased from

Jan 1 - 1916, to Mar 28 1928

that I last saw him alive on Mar 28 1928

and that death occurred, on the date stated above, at 9:00 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Pressure

(duration) yrs. mos. ds.

CONTRIBUTOR  
(Secondary)Hypertension  
(duration) 10 yrs. 2 mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Physical signs

(Signed) C. F. Hughes M.D.

(Address) 3701 R. South

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

St Mary's Hospital Mar 31 1928

20 UNDERTAKER

ADDRESS

A. S. Marshall 5539 Fall Road

32255

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 32255

PLACE OF DEATH

Y OF BALTIMORE; (No.

ST.

WARD)

FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (Write the word)

male colored  
married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY That I attended deceased from  
8/26, 1924, to March 28, 1924.

that I last saw him alive on March 22, 1924

and that death occurred, on the date stated above, at 10, 304 m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

2256

HEALTH DEPARTMENT-CITY OF BALTIMORE

E 32256

CERTIFICATE OF DEATH.

129 ✓

1-PLACE OF DEATH

City of BALTIMORE: (No. 670 W Franklin St. 17-24 Ward)

2-FULL NAME Oliver Kirk

(a) RESIDENCE NO. 670 W Franklin St. Ward

(Usual place of abode) Length of residence in city or town where death occurred 30 yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kirk

DATE OF BIRTH (month, day, and year) May 1878

AGE Years 49 Months 10 Days IF LESS than 1 day...hrs. or...min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County (State or country)

10 NAME OF FATHER John Kirk

11 BIRTHPLACE OF FATHER (city or town) Balt. County (State or country)

12 MAIDEN NAME OF MOTHER Lath Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore County (State or country)

14 Informant Mary Kirk (Address) 670 W. Franklin St.

15 Filed G. HAMMOND JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 27 28

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1928, to 3-27, 1928, that I last saw him alive on 3-26, 1928, and that death occurred, on the date stated above, at 2 30 m.

THE CAUSE OF DEATH\* was as follows: Ch. Interstitial Nephritis Uremia

CONTRIBUTORY (Secondary) Acute Nephritis (duration) yrs. mos. 2 ds.

(duration) yrs. mos. 5 ds.

15 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ray McQuay, M. D.

(Address) 4001 Bay View

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial

20 UNDERTAKER George J. Ruth 1735 Highland Ave

30 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32257

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

If married, widowed, or divorced

HUSBAND of

or WIFE of

Roder P. Charles

DATE OF BIRTH (month, day, and year)

July 12, 1863

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

8

18

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Hans Charles

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary P. Webb

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Roder P. Charles  
2113 Doubler Ave

15

30 1926

19

Pm

C. HANCOCK JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 29, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb

1927, to

March 29, 1928.

that I last saw him alive on

March 29, 1928.

and that death occurred, on the date stated above, at

3,30 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic

Interstitial nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterial Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) E. W. F. Zimmerman, M. D.

9/28/28 (Address) 2858 Bayford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem.

Apr 2 1928

20 UNDERTAKER

ADDRESS

Joseph Syfer

1600 W. Hatt  
Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32258

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

Y OF BALTIMORE: (No.

WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

(If married, widowed, or divorced HUSBAND of (or) WIFE of)

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

Filed

1928

HAMILTON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

3/23, 1928, to 3/27, 1928.

that I last saw him alive on 3/27, 1928.

and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

1928, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

259

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

32259

1-PLACE OF DEATH

City of BALTIMORE: (No. 3103 E. Fairmount Ave. 6 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M. Lewis

(a) RESIDENCE NO. 3103 E. Fairmount Ave. 7 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day... hrs. or... min.. 2 7 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER John R. Lewis

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Catharine E. Stabler

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.  
(State or country)

14 Informant John R. Lewis (Father)  
(Address) 3103 E. Fairmount Ave.

15 30 1928 HAMMON JONES, M.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

I HEREBY CERTIFY, That I attended deceased from Mar 27, 1928, Mar 29, 1928, that I last saw him alive on Mar 29, 1928, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH was as follows: Talent foramen (Cerebral)

CONTRIBUTORY (Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination  
(Signed) [Signature], M. D.  
(Address) 1057 Linwood Ave.

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery  
20 UNDERTAKER Lilly & Zeiler Inc

Mar. 30 1928  
ADDRESS 403 E. Wolfe St.

32260

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 32260

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 S. Streeper ST., 1 WARD)

2-FULL NAME Leo Joseph Botterweich

(a) RESIDENCE No. 1106 S. Streeper ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. Now long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Estella A. Botterweich

7 DATE OF BIRTH (month, day, and year) Oct. 14 1900

8 AGE Years 28 Months 5 Days 13 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Peter E. Botterweich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Struckfus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Estella A. Botterweich Wife (Address) 1106 S. Streeper St.

15 Filed 30 1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1928

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1928, to March 27, 1928, that I last saw him alive on March 27, 1928, and that death occurred, on the date stated above, at 11:30 a.m. The CAUSE OF DEATH\* was as follows:

Pleurisy Pneumonia

CONTRIBUTORY (Secondary) Chronic Bronchitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home (duration) yrs. 2 mos. ds.

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Rosenblatt M. D.

3/27, 1928 (Address) 3018 O. Donnell St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Sacred Heart Cemetery

UNDERAKER Lilly &amp; Green Inc. DATE OF BURIAL March 31 1928 ADDRESS 4035 Wagon St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32261

CERTIFICATE OF DEATH.

E 32261

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 6-9 Ward)

2-FULL NAME Harry Silver

(a) RESIDENCE NO. 200 N. Ann St. St.          Ward         

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.         

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced. (write the word) Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Hinda Silver

DATE OF BIRTH (month, day, and year) ----1869

AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 59

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer         

9 BIRTHPLACE (city or town)

(State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1439 E. Balto. St.

15 Filed 1928 Mar 30 1928 HALK. B. COOPER, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidental Burns. Home burned on Mar 26/28.

CONTRIBUTORY (Secondary)

(Signed) J. H. Brown (Coroner) M. D.

3/30/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?         

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Rehman Roseclale

Date of Burial 3/30 1928

20 UNDERTAKER

Jack Lewis 1439 E. Balto. St.

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32262

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 A Bentelaw ST., 45-68)

2-FULL NAME Henry Neprotorsky

(a) RESIDENCE NO. 1728 A Bentelaw ST.

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6 If married, widowed, or divorced HUSBAND of or WIFE of Sophia Neprotorsky

7 DATE OF BIRTH (month, day, and year)

AGE

Years 76

Months —

Days —

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Abraham Neprotorsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Baltimore St.

15 30-1928

G. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 9, 1928, to March 27, 1928, that I last saw him alive on March 29, 1928, and that death occurred, on the date stated above, at 3:30 a. m. The CAUSE OF DEATH\* was as follows:

coronary artery disease

(duration) yrs. 6 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Whitehouse, M. D.

, 19

(Address) 1810 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

32263

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32263

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 1401 S. Charles St. St. 23-33 Ward)

2-FULL NAME... Harry M. Morris

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1401 S. Charles St. St. .... Ward ....

Length of residence in city or town where death occurred Life 50 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, Widowed (Write the word.)

If married, widowed, or divorced HUSBAND of (or) WIFE Sarah H. Morris

DATE OF BIRTH (month, day and year) Jan 11 - 1857

AGE, 71 yrs. 2 mos. 18 ds. If LESS than 1 day, .... hrs. or .... min.?

### OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Retired  
(b) General nature of industry, business, or establishment in which employed (or employer)....  
(c) Name of employer.....

BIRTHPLACE (city or town, State or Country), New York

PARENTS

10-NAME OF FATHER Samuel Morris

11-BIRTHPLACE OF FATHER (city or town, State or Country) Germany

12-MAIDEN NAME OF MOTHER Gelda Bikemes

13-BIRTHPLACE OF MOTHER (city or town, State or Country) Germany

14- (Informant) Julian Morris (Address) 1401 S. Charles St.

15- C. HAMMON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3/29/28

HEREBY CERTIFY, That I attended deceased from March 28, 1928, to March 29, 1928, that I last saw her alive on March 29, 1928, and that death occurred, on the date stated above, at 10:30 a.m. The CAUSE OF DEATH\* was as follows:

Angina Pectoris

CONTRIBUTORY (Secondary) Chronic Hypertension

18-Where was disease contracted If not at place of death? Two

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? (Signed) John A. Scheunert, M. D. Address) 1337 S. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Beth Netherland DATE OF BURIAL, April 10, 28

20-UNDERTAKER Jack Lewis ADDRESS 1401 S. Charles St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32264

## CERTIFICATE OF DEATH.

E 32264

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1536 woodyear St., 15-21 Ward)

2-FULL NAME Abraham Briscoe

(a) RESIDENCE NO. 1536 Woodyear St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? mos. da. yrs. mos. da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 Color or Race colored 5 Single, Married, Widowed, or Divorced, (write the word) married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE 61 Years 7 Months 3 Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

15 FEB 1928

J. J. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28-28

17

I HEREBY CERTIFY, That I attended deceased from

11-10-19-28 to 3-28-19-28

that I last saw him alive on 3-28-19-28

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH\* was as follows:

Myocarditis with Mitral Insufficiency.

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) J. J. JONES, M. D.

, 19 (Address) 1403 Park Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL St. Marys Co Md

Date of Burial

20 UNDERTAKER

ADDRESS

Thomas E. Kelton

1303 Pursatman St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32265

## CERTIFICATE OF DEATH.

E 32265

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 1547 Woodyear ST., 15-21 WARD)

## FULL NAME

Baby boy Gardner

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

10

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

X

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

maleblackmarried, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## DATE OF BIRTH (month, day, and year)

3-19-28

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.XX10

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workX(b) General nature of industry,  
business, or establishment in  
which employed (or employer)X

(c) Name of employer

XBIRTHPLACE (city or town)  
(State or country)Baltimore, Md

## 10 NAME OF FATHER

Walter Gardner11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Balt.  
Md.

## 12 MAIDEN NAME OF MOTHER

Josephine Halland13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Bowie  
Md.Informant  
(Address)Josephine Gardner  
1547 Woodyear

30 1928

C. HAMPSHIRE JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3-29 1928

17

I HEREBY CERTIFY, That I attended deceased from  
3-19, 19 28, to 3-29, 19 28.that I last saw him alive on 3-29, 19 28.and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. Alexander Kovey, M. D.

, 19

(Address) 1576 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Mt. Auburn cemetery3/30 1928

## 20 UNDERTAKER

## ADDRESS

Thomas G. Kelson1303  
Presstman



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32266

CERTIFICATE OF DEATH

REGISTERED NO.

E 32266

1-PLACE OF DEATH

City of BALTIMORE: (No. 2914 Ingleswood Ave. St. Hamlet Ward 43)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Grevelding Fisher

(a) RESIDENCE NO.

2914 Ingleswood Ave. St. Hamlet Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 24 ds.

How long in U. S. if of foreign birth 40 yrs. 10 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

May 4 1857

7 AGE

Years 70 Months 10 Days 24

IF LESS than 1 day... hrs. or... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Climents Schwartz

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Stimpf

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mr. Wilhelmina Kraemer  
2914 Ingleswood Ave. Hamlet

Filed

19

FRANKSON JONES, M

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

May 1 to March 25 1928

that I last saw him alive on March 26 1928

and that death occurred, on the date stated above, at 5-40 P M.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis  
of Left

(duration) yrs. 3 mos. 3 da.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) yrs. 1 mos. 1 da.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Leucocytes

(Signed) W. H. Jones M. D.

(Address) 2914 Ingleswood Ave. Hamlet

\*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery

April 31 1928

20 UNDERTAKER

ADDRESS

Henry Jacobson

1301 E. Eads

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32267

CERTIFICATE OF DEATH

90 E 32267

1-PLACE OF DEATH

City of BALTIMORE: (No. *624 Aull*)

2-FULL NAME

(a) RESIDENCE NO. *624 Aull*

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred *8* yrs. - *4* mos. - *4* ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? *1* yr. *1* mos. *1* da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced, HUSBAND of *Theresa Robinson* (or) WIFE of

DATE OF BIRTH (month, day, and year) *March 15 1870*

7 AGE Years *58* Months *-* Days *14* IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Shoe Hat Maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balt. Md* (State or country)

10 NAME OF FATHER *Fredrick Derfotm*

11 BIRTHPLACE OF FATHER (City or town) *Balt. Md* (State or country)

12 MAIDEN NAME OF MOTHER *Sophia Nordt*

13 BIRTHPLACE OF MOTHER (city or town) *Balt. Md* (State or country)

14 Informant *Mrs. Christina Nordt* (Address) *624 Aull St*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 29 1928*

17 I HEREBY CERTIFY, That I attended deceased from *March 28 1928* to *March 29 1928*

that I last saw him alive on *March 29 1928* and that death occurred, on the date stated above, at *12:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dilatation*

CONTRIBUTORY (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. (Secondary) *Myocarditis*

(duration) \_\_\_\_\_ yrs. *4* mos. \_\_\_\_\_ da.

18 Where was disease contracted

If not at place of death?

Was there an autopsy? *No* Date of \_\_\_\_\_

What test confirmed diagnosis? *Physical Exam*

(Signed) *Geo. W. Ferguson M.D.*

3/29/28 (Address) *401 E 25th St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Holy Redeemer Cemetery* *March 2 1928*

20 UNDERTAKER

ADDRESS

*Henry Wood Lins* *1516 E. 1st*

MAR 30 1928

HARRISON JONES, M.D. Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

32268

CERTIFICATE OF DEATH.

125 ✓  
E 32268  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mary 1004 St., 27-44 Ward)

2-FULL NAME

John B. Schneider

(a) RESIDENCE NO.

3300 Rueskott Ave

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

58 yrs. - mos. ds.

ds.

How long in U. S., if of foreign birth?

Life

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Theresa B. Schneider

6 DATE OF BIRTH (month, day, and year)

Not state

AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

5-3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

md

10 NAME OF FATHER

Joe Schneider

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balt

12 MAIDEN NAME OF MOTHER

Mary Ward

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balt

14

Informant (Address)

Theresa B. Schneider  
3300 Rueskott Ave

MAR 30 1928

JAMISON JONES, M.  
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 29

1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held au.....

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

(Inquest, au-

topsy or inquiry.) and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Pancreatitis

Complicated

(duration).....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

Died few hours after  
(duration).....yrs. ....mos. ....ds.

(Signed)

Theresa B. Schneider  
(Coroner)

M. D.

Mar 29, 1928 (Address)

W. H. H. H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the

State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cemetery

Date of Burial Apr 2 1928

UNDERTAKER

Henry Jacobson

ADDRESS

1301 E. Eager St

32269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 32269

1-PLACE OF DEATH

City of BALTIMORE: (No. 4228 Woodlea Ave. St. 27th Ward)

2-FULL NAME

Violet V. Schwartz

(a) Residence No.

4228 Woodlea Ave.

(Usual place of abode)

Ward.

Length of residence in city or town where death occurred

36 yrs.

mos.

8 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female	4-COLOR OR RACE White	5-STATUS Single, Married, Widowed, or Divorced, (Write the word.) Married
6-If married, widowed, or divorced, HUSBAND (or) WIFE of John Schwartz		
7-DATE OF BIRTH (month, day and year) March 21-1892		
8-AGE 36 yrs. 8 mos. 8 ds.		
9-If LESS than 1 day, hrs. or min.?		

OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work... Housewife
- (b) General nature of industry, business, or establishment in which employed (or employer)...
- (c) Name of employer...

10-BIRTHPLACE (city or town) (State or Country).

Md.

PARENTS

10-NAME OF FATHER	11-BIRTHPLACE OF FATHER (city or town) (State or Country)
Wm. H. Trigg	Md.
12-MAIDEN NAME OF MOTHER	13-BIRTHPLACE OF MOTHER (city or town) (State or Country)
Unkenned	Md.

14- (Inferant) John Schwartz  
(Address) 4228 Woodlea Ave.

15- Filed 1928

C. H. JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 29-1928

17- I HEREBY CERTIFY, That I attended deceased from Apr 1-1928 to Mar 29-1928 that I last saw her alive on Mar 28-1928 and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis

CONTRIBUTORY (Secondary)

18-Where was disease contracted (Duration) yrs. 6 mos. 3 ds.

18-Where was disease contracted (Duration) yrs. 6 mos. 3 ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. Edmont M.D. (Address) 19128 Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park April 2, 1928

20-UNDERTAKER Wm. H. Valentin 2226 Aiken



32270

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 Linden Ave. ST. 14-70 WARD)

FULL NAME Etta Marshall Stauffer

(a) RESIDENCE NO. 1803 Linden Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

White

Widowed

married, widowed, or divorced

HUSBAND of

(or) WIFE of

Frank H. Stauffer

DATE OF BIRTH (month, day, and year)

Aug 3-1873

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84

7

25

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Penn

10 NAME OF FATHER

Junior P. Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

May C. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa

Informant (Address)

Etta M. Stauffer

File

1928

H. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/28/28

17

I HEREBY CERTIFY, That I attended deceased from Mar. 21, 1928, to Mar. 28, 1928, that I last saw him alive on Mar. 28, 1928, and that death occurred, on the date stated above, at 7:30 P. M. The CAUSE OF DEATH\* was as follows:

Myocardium

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

H. H. Jones

M. D.

(Address) 2512 Columbia Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

J. J. Jones, Jr.

H. H. Jones

E 32271

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

\* 38 E 32271

PLACE OF DEATH *Balto City Hospital*Y OF BALTIMORE: (No. *13 Balto Md.* ST. *16-37* WARD)FULL NAME *Mary Hare*(a) RESIDENCE NO. *Ridge Road, Catonsville Md.*  
(Usual place of abode)Length of residence in city or town where death occurred *12* yrs. mos. *15* ds. How long in U. S., if of foreign birth? (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

X *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *widow*married, widowed, or divorced  
HUSBAND of *Louis Hare*  
or WIFE ofDATE OF BIRTH (month, day, and year) *Oct 16 1880*AGE Years Months Days If LESS than 1 day, hrs or min.  
*8* *5* *13*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Westminster Md*  
(State or country)10 NAME OF FATHER *Joseph H Taylor*11 BIRTHPLACE OF FATHER (city or town) *Georgia*  
(State or country)12 MAIDEN NAME *M. Scott*13 BIRTHPLACE OF MOTHER (city or town) *Princeton Md*  
(State or country)Informant *Balto City Hosp*  
(Address) *13 Balto Md*5 Filed *1026* HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-29-28*17 I HEREBY CERTIFY, That I attended deceased from *3-16-1928* to *3-29-1928* that I last saw her alive on *3-29-1928* and that death occurred, on the date stated above, at *12:10 P* m.  
The CAUSE OF DEATH\* was as follows:*General Paralysis of Insane*(duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) *Luetic Infection*  
(duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Serological + Clinical*  
(Signed) *Phil Pearlman*, M. D.3/29/1928 (Address) *Balto City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
*Westminster Md* DATE OF BURIAL *3/31/28*20 UNDERTAKER *Wm J. Dickson Sons* ADDRESS *Pa No Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32272

CERTIFICATE OF DEATH.

188-003  
E 32272

1-PLACE OF DEATH

City of BALTIMORE: (No.

Washington Blvd near 6<sup>th</sup> St  
St. 75-72 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give his NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Louis Geisselman

(a) RESIDENCE NO.

1452 Main St, Mt Vernon Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds.

How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day and year)

Oct 3<sup>rd</sup> 1850

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

77 5 24

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Cement Finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

Ludwig Geisselman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Wm Geisselman 1452 Main St Mt Vernon

15 Filed

19

C. HARRISON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year)

March 29<sup>th</sup> 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, autopsies or inquiry.)

That said deceased came to this death on the day stated above.

18 CAUSE OF DEATH was as follows: Fractured Skull - R. Leg cut off below knee - R. Hip fractured

CONTRIBUTORY CAUSE was as follows: Run over by auto

Sand truck

Signed Thos B. Norton M. D. Coroner

29<sup>th</sup> 1928 (Address) Curtis Bay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See report of coroner's jury.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs., mos., ds. In the State..... yrs., mos., ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR

Date of Burial

HEMORYAN

Philadelphia Pa

April 2 1928

20 UNDERTAKER

George J. Smith

ADDRESS 1532

Hollins St

32273

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32273

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

TY OF BALTIMORE: (No. *So. Balt Gen Hosp* ST. *18-24* WARD)

### 2-FULL NAME

*John Gannon*

(a) RESIDENCE NO.

*916 W. Pratt St.*

(Usual place of abode)

Length of residence in city or town where death occurred *600* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male*

*White*

*Widowed*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Unknown*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*600*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Labr.*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Water Department*

(c) Name of employer

*City*

BIRTHPLACE (city or town) (State or country)

*Md.*

10 NAME OF FATHER

*Michael Gannon*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

14

Informant (Address)

*M. John W. Thomas 206 Riggs Ave*

MAR 30 1928

JAMES JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 29 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 27*, 19 *28*, to *March 29*, 19 *28*, that I last saw him alive on *March 29*, 19 *28*, and that death occurred, on the date stated above, at *1:30* A. M. The CAUSE OF DEATH\* was as follows:

*Pulmonary Edema*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Artero-Sclerotic Card. Vas. Renal Dis.* (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical symptoms*

(Signed) *E. Thomas*, M. D.

, 19 (Address) *So. Balt. Gen. Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*St. Peter's Cem. John J. Gannon & Son*

*Mar 31 1928*  
*York St.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32274

## CERTIFICATE OF DEATH.

100-001  
E 32274  
REGISTERED NO.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 76 Darby St)

13-57  
ST. WARD

FULL NAME

Leonard Fisher

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs

mos

ds.

How long in U. S., if of foreign birth?

yrs.

mos

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

White

Widowed

married, widowed, or divorced

HUSBAND of

(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
March 24, 1928, to March 25, 1928.

that I last saw him alive on March 28, 1928

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

March 27, 1928 (Address) 8429 Chestnut St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Filed,  
MAR 30 1928HAMPDEN ROYCE, M. D.  
Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

32275

CERTIFICATE OF DEATH.

E 32275

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3604 Hickory Ave 3-52 Ward)

2-FULL NAME Ethel M. Leister

(a) RESIDENCE NO. 3604 Hickory Ave St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced. (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

7 DATE OF BIRTH (month, day, and year) May 26, 1919

AGE 9 Years 10 Months 2 Days 10 LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) School #5320

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Barroll Co

(State or country) \_\_\_\_\_

10 NAME OF FATHER Elmer Leister

11 BIRTHPLACE OF FATHER (city or town) md (State or country)

12 MAIDEN NAME OF MOTHER Maudie Britweiger

13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

14 Informant Maudie Leister (Address) 3604 Hickory Ave

15 Filed 1920 19 11/11/20 (M. D.) Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1920

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Brusky Pneumonia (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. M. Morrissey M. D. (Coroner)

3/29 1920 (Address) 3632 Roland

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Cema Date of Burial March 31, 1920

20 UNDERTAKER Chenoweth ADDRESS 3615 Chestnut

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32276

## CERTIFICATE OF DEATH.

148 E 32276

### 1-PLACE OF DEATH

TY OF BALTIMORE: (No. Franklin Sq. Hosp ST. 19-28 WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reba Oaden

(a) RESIDENCE NO. 110 S. Gilmer  
(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred 17 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced  
(or) WIFE of John A. Oaden

DATE OF BIRTH (month, day, and year) Aug 3, 1910

AGE Years Months Days If LESS than 1 day, hrs. or min.  
17 7 25

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER Wm. Blaney

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Corah B. Klein

13 BIRTHPLACE OF MOTHER (city or town) Russia  
(State or country)

14 Informant Corah B. Blaney  
(Address) 110 S. Gilmer St.

15 R 30 1928 C. HAMMOND JONES, M.D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1928 to Mar. 28, 1928.  
that I last saw her alive on Mar. 28, 1928.  
and that death occurred, on the date stated above, at 8:20 m.

The CAUSE OF DEATH\* was as follows:  
Acute Nephritis compli-  
cating pregnancy.

(duration) yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? 1  
(Signed) J. Morris Reese  
, 19 (Address) Medical Arts Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

St. Olivet Mar 30 28

20 UNDERTAKER ADDRESS  
Harry H. Witzke 1531 W. Lombard

## E 32277 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32277  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1-13 ST. WARD)

2-FULL NAME *Marion Taylor*(a) RESIDENCE NO. *908 McDermott* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *25* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*6 married, widowed, or divorced HUSBAND of (or) WIFE of. *Marion Taylor*7 DATE OF BIRTH (month, day, and year) *Jan 57*

8 AGE Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*10 NAME OF FATHER *John S. Simpson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Claudia*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Virginia*14 Informant (Address) *Reverend*15 Filed: *19* *HAMPSON JONES, M.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/27/1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar 10, 1927* to *Mar 27, 1928* that I last saw *deceased* live on *Mar 27, 1928* and that death occurred, on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*myocarditis, chronic & acute  
arteriosclerosis  
hypertension*(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *General & Sidel*  
(Signed) *C. Holmes Boyd*, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Ashbury Cemetery**3/30/28*

20 UNDERTAKER

ADDRESS

*Mrs. R. G. Elliott**Ashbury*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32278

## CERTIFICATE OF DEATH.

REGISTERED NO. 32278

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 345 Canal St. 11-24 Ward)

## 2-FULL NAME Cambridge Herring

(a) RESIDENCE NO. 345 Canal St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Col

Married

6 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Russian Herring

7 DATE OF BIRTH (month, day, and year)

Unknown, 1867

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

61

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Common labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Mobile Alabama

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Alabama

14

Informant

(Address)

Emma Jones 830 Barnes St

15

Filed

MAR 30 1928 HARRISON JONES, Jr.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/28

17

I HEREBY CERTIFY, That I attended deceased from  
Mar. 19, 1928, to Mar 27, 1928,  
that I last saw him alive on Mar 27, 1928,  
and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH\* was as follows:

Paralysis

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) John H. Thompson, M. D.

(Address) 1012 N. Lafayette

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

Wm. G. Elliott  
Address 1725 Ashland

2279

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 E 32279

1-PLACE OF DEATH

Y OF BALTIMORE: (No. *Union Memorial Hosp 17-49* ST. *17-49* WARD)

2-FULL NAME

*Col. William Henry Morgan*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

*Glamorgan*

ST.

WARD

*Alliance, Ohio*

Length of residence in city or town where death occurred

yrs.

mos.

6

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*

If married, widowed, or divorced

HUSBAND of

*Mrs. H. H. Morgan*

DATE OF BIRTH (month, day, and year)

*June 1<sup>st</sup> 1865*

AGE

Years

Months

Days

If LESS than

1 day, hrs

or min.

*62**10**2*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Manufacturer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Ohio*

10 NAME OF FATHER

*J. R. Morgan*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Mass*

12 MAIDEN NAME OF MOTHER

*Elizabeth Merla*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Mass*

Informant (Address)

*Mrs. W. H. Morgan Alliance, Ohio*

APR 30 1928

P. J.

JAMISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 29 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 23<sup>rd</sup> 1928*, to *March 29 1928*.that I last saw him alive on *March 29 1928*.and that death occurred, on the date stated above, at *11:25 P. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma (Lymphoid) of the  
C. retropharyngeal lymphatic*(duration) yrs. *about 7* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *March 28 1928*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Thomas C. Offo*, M. D.1928 (Address) *Union Memorial Hospital - City*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Alliance Ohio**March 30 1928*

20 UNDERTAKER

ADDRESS

*Henry H. Jenkins Sonoco - Oakland*

32280

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

218 N. Mount St.

ST. 19-27 WARD

## 2. FULL NAME

Catherine Mathews

(a) RESIDENCE NO.

218 N. Mount St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

35

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32280

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

EX  
Fair

Col

Widow

If married, widowed, or divorced

HUSBAND or (or) WIFE of

Carrison Mathews

DATE OF BIRTH (month, day, and year)

Unknown 1878

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

30

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Fallon Co Ind

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Edith Neas

215 N. Morris St.

15

Filed

19

C. HAMMOND JONES, M. D.

Registrar

19-27

WARD

ST.

WARD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30 19 28

17

I HEREBY CERTIFY, That I attended deceased from March 1st., 1928 to March 30th. 28. that I last saw her alive on March 29th., 1928. and that death occurred, on the date stated above, at 12 10 a.m.

The CAUSE OF DEATH\* was as follows:

Mitral Ins.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Ch. Int. Neph.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted At place of death if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed)

Walter J. Jackson

Exam. Urin. ana. M. D.

320 1928 (Address)

1631 W. Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

M. H. Hulse

4-1 1928

Sam W. Case

1400 Market

E 32281

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32281

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 E 20th ST. 12-19 WARD)

2-FULL NAME Hester A Robey

(a) RESIDENCE NO. 302 E 20th

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles J Robey

DATE OF BIRTH (month, day, and year) Dec 9, 1854

AGE Years 73 Months 3 Days 21 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER John Nizer

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Eleng Biddson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14

Informant (Address) Marion A Robey 302 E 20th St

APR 30 1928

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1928

17

I HEREBY CERTIFY, That I attended deceased from November 2nd, 1927, to March 28th, 1928,

that I last saw her alive on March 28th, 1928,

and that death occurred, on the date stated above, at 9:00 p. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Liver

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 302 E-20th St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Jm Conrad Boley, M. D.

, 19 (Address) 1901 Maryland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park

DATE OF BURIAL

3/30 1928

20 UNDERTAKER

ADDRESS

302 E 20th St



32282

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32282

## CERTIFICATE OF DEATH.

101-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 W. Pine 19-27)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Colored

Single

If married, widowed, or divorced, HUSBAND of (or) WIFE of

Single

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

Nov, 23, 1927

4

5

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore md

10 NAME OF FATHER

Wm Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Ella Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. C.

14

Informant (Address)

William Jenkins 1517 High St

15

R 30 1928

C. HAMPSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

29 19 28

17

I HEREBY CERTIFY, That I attended deceased from

Nov 26, 19 28, to Nov 27, 19 28

that I last saw her alive on Nov 28, 19 28

and that death occurred, on the date stated above, at 4-9 m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mount Zion

3-30 1928

Joseph A. Smith

1099 Mont

2283

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 E 32283

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 South Mount

ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John William Langdoef

(a) RESIDENCE NO. 102 South Mount

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred 82 yrs. 11 mos. 28 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

white

Married

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Amalia J. Langdoef

DATE OF BIRTH (month, day, and year)

Mar 29-1845

AGE

Years

Months

Days

If LESS than

82

11

28

1 day, hrs.

or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

Butcher

(c) Name of employer

Self

BIRTHPLACE (city or town)  
(State or country)Baltimore city  
md

10 NAME OF FATHER

John Langdoef

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Eva Asch

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

also know

Informant  
(Address)Amalia J. Langdoef  
102 South Mount

Filed

1928

C. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 28-1928

17

I HEREBY CERTIFY, That I attended deceased from Aug 3, 1927, to Mar. 28, 1928, that I last saw him alive on Mar 27, 1928, and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma Colon + Rectum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

Clinical

(Signed) E. Heller Herring M. D.  
3/30/28 Address) 2000 Hollins St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

3/31/1928

UNDETAILED

ADDRESS

Gen. Hubert Son 2503 Elmwood

E 32284

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32284

PLACE OF DEATH

Y OF BALTIMORE: (No. 305 Collins ave

FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

37 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

male white married

HUSBAND of (or) WIFE of

Albert Moore

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

62

5

1

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

BIRTHPLACE (city or town) (State or country)

Spottwood

10 NAME OF FATHER

James Biston

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Mrs Hattie May Robinson

Filed

19

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 29 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 27, 1928, to March 29, 1928,

that I last saw him alive on March 29, 1928,

and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH\* was as follows:

Chronic Intercapillary Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

At Home

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Physical symptoms and chemistry analysis

(Signed)

March 28, 1928 (Address)

Charles G. B. M. D. 1111 W. Berrall St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

DATE OF BURIAL

4/2/1928

20 UNDERTAKER

Geo. W. Bell &amp; Son 2503 Edmondson ave

32285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 32285

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 S Pulaski ST. WARD)

2. FULL NAME Thomas A. Law

(a) RESIDENCE NO. 29 S Pulaski ST. WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 7 1904

AGE Years Months Days 24 2 22 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER Mr. J. Law

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Conners

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant (Address) Wm. J. Law Jr. 29 S Pulaski ST. BALTIMORE, MD.

15 1928 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1928

17 I HEREBY CERTIFY That I attended deceased from January 1928 to March 29 1928. That I last saw him alive on March 28 1928. and that death occurred, on the date stated above, at 1:15 p. m. The CAUSE OF DEATH\* was as follows:

Acute cardiac dilatation

CONTRIBUTORY (Secondary) Pulmonary Th. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7 (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) John A. Schenck M. D.

, 19 (Address) 1337 S. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Catholic Cem

UNDERTAKER George A. Turkey

DATE OF BURIAL 31 28 ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

2286

## CERTIFICATE OF DEATH.

90 E 32286

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

426 E. 22nd 12-50 ST. WARD)

## 2-FULL NAME

Charlotte Hiron

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

426 E. 22nd

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

7

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male White

Married

married, widowed, or divorced

HUSBAND of (a) WIFE of

Henry Hiron

DATE OF BIRTH (month, day, and year)

Jan. 20, 1841

AGE

Years

Months

Days

87

2

9

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Upton Magna England

## 10 NAME OF FATHER

John Humphreys

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

## 12 MAIDEN NAME OF MOTHER

Emma Pugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

Informant (Address)

Mr. Henry Hiron 426 E. 22nd St

5

C. HAMPSON JONES, M. D.

0 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 29, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 1, 1928, to Mar. 29, 1928.

that I last saw him alive on Mar. 28, 1928.

and that death occurred, on the date stated above, at

7:35 P. M.

The CAUSE OF DEATH\* was as follows:

Cardiac dilatation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Old age

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Unknown

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Physical

(Signed)

Thos. H. Blake

M. D.

, 19

(Address)

719 Mid Auto Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Wallingford Conn.

DATE OF BURIAL

Mar. 31, 1928

20 UNDERTAKER

Wm. J. Hiron

ADDRESS

None

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32287

## CERTIFICATE OF DEATH.

60-001 32287

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 E. 31st ST. 9-46 WARD)

### 2. FULL NAME

(a) RESIDENCE NO. 1617 E. 31st ST.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Address

15

1928

C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1928

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to Mar 29, 1928, that I last saw him alive on Mar 28, 1928, and that death occurred, on the date stated above, at 4:35 p. m.

The CAUSE OF DEATH\* was as follows:

Myocard Infarction

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

6 N. Meyer Jr., M. D. 3/19, 1928 (Address) 10' 27 E. 31st St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32288

32288

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 8-13 Ward)2-FULL NAME Wm. Meade(a) RESIDENCE NO. 1915 E. Biddle

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

6 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) Dec 15/26

AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	3 6	14	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Va

## 10 NAME OF FATHER

Wm. Meade

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va12 MAIDEN NAME OF MOTHER Martha Riddle

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.14 Informant Mother  
(Address)15 1928 C. HAMPSON JONES, M. D.  
Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry find that said deceased came to his death  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Septicemia following Tonsillitis

## (Autopsy)

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)(Signed) J. J. [Signature] M. D.  
(duration) yrs. mos. ds.  
(Coroner)19 3/30/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Chase City via March 30/28

## 20 UNDERTAKER

ADDRESS

Mrs R A Elliott 172 Ashland

32289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.

723 Kersh Court 10-14 WARD

2-FULL NAME

Charlie Stell  
723 Kersh Court

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

3 mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Colored

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Infant

BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Charlie Stell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Topeka, Kansas

12 MAIDEN NAME OF MOTHER

Lula Whitehead

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Richmond, Va.

14

Informant (Address)

Charlie Stell  
723 Kersh Court

15

File

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/30 1928

17

I HEREBY CERTIFY, That I attended deceased from

3/29 1928 to 3/30 1928

that I last saw him alive on

3/30 1928

and that death occurred, on the date stated above, at

89 m

The CAUSE OF DEATH\* was as follows:

acute Broncho Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Autopsy Findings

(Signed) A. H. Hornstein M. D.

3/30 1928 (Address) 733 August St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Calvary cemetery March 31 1928

20 UNDERTAKER

ADDRESS

Mrs R A Elliott 725 Ashland Ave



32290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 74-E 32290

1-PLACE OF DEATH

City of BALTIMORE: (No. 1019 E. Chapel St. St., 7-13 Ward)

2-FULL NAME Mary Brown

(a) RESIDENCE NO. 1019 N. Chapel St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female col widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

1847

AGE Years 81 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Robt Elliott (Address) 1725 Ashland Ave

15 1928 C. HAMMOND JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29/28

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows: Probably Apoplexy

CONTRIBUTORY (Secondary)

(Signed) J. S. H. B. (Coroner) M. D.

3/30-28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER Mrs. R. A. Elliott 1725 Ashland Ave

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32291

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary 6-4 Ward)

2-FULL NAME Elsie Cornes

(a) RESIDENCE NO. Joppa, Md.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. 17

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

March 12/1904

AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

24

0

17

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

Joppa, Md.

10 NAME OF FATHER

Wm. J. Cornes

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Md

12 MAIDEN NAME OF MOTHER Clara Akers

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Md.

14

Informant Celia Cornes

(Address)

5902 Falls Road, Balto

1928

G. HAMPTON JONES, M. D.

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 29/28

17

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidental Burns, Gasoline Stove exploded at home

(duration) .....yrs. ....mos. 26 ds.

CONTRIBUTORY Nephritis

(Secondary)

(Signed) J. S. Jones M. D.

(Coroner)

(Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Abingdon M. E. Cem Apr 1 1928

20 UNDERTAKER

ADDRESS

10 E McComas Abingdon Md

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32292

32292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital Ward 1-3)

2-FULL NAME Kenneth Hasenei

(a) RESIDENCE NO. 417 S. Madeira St St.          Ward         

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Mar 4/1912

8 AGE Years 16 Months 0 Days 13 IF LESS than 1 day.....hrs. or.....min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Apprentice  
(b) General nature of industry, business, or establishment in which employed (or employer) Lanahan & Co  
(c) Name of employer Printers

10 BIRTHPLACE (city or town) Balto., Md.  
(State or country)

11 NAME OF FATHER John Hasenei

12 BIRTHPLACE OF FATHER (city or town) Balto., Md.  
(State or country)

13 MAIDEN NAME OF MOTHER Amelia Schram

14 BIRTHPLACE OF MOTHER (city or town) Balto., Md.  
(State or country)

15 Informant Father  
(Address)

16 REGISTRAR          Registrar

REGISTERED NO.         

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
Arsphenamine Poisoning-Accidental

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signature)          M. D.  
(Coroner)

3/29/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial 3/30/28

20 UNDERTAKER Joseph Ahrens ADDRESS 221 Bway

HEALTH DEPARTMENT—CITY OF BALTIMORE

32293

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 1-1 Ward)

2-FULL NAME James H. Howes.

(a) RESIDENCE NO. 205 S. Robinson St. St. 1-1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male.

White.

Married.

a If married, ~~write name of~~  
HUSBAND of  
~~XXXXXXX~~

Blanche S. Howes.

DATE OF BIRTH (month, day, and year)

September 5, 1881.

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

46

6

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chief Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

Baugh Chemical Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Rockland, Md.

10 NAME OF FATHER

Richard T. Howes.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Rockland, Md.

12 MAIDEN NAME OF MOTHER

Mary Shipley.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Laurel, Md.

14

Informant

Blanche S. Howes. (wife)

(Address)

205 S. Robinson St.

15

FILED

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 29, 1928

17

I HEREBY CERTIFY, That I, took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Traumatic thigh infection, amputation of right arm. Caught in electric machinery gears. Accidental death.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) [Signature] M. D. (Coroner)

8/30, 1923 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death: Baugh Chemical Co. 11th Ave & Clinton St.

Former or usual residence March 13, 1923.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Louisa Park Cemetery Date of Burial Mar 31 1928

20 UNDERTAKER

John F. Denny ADDRESS 715 Light St



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32294

## CERTIFICATE OF DEATH.

90 E 32294

### 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward 9-46)

2-FULL NAME Thomas R. Gates.

(a) RESIDENCE NO. 1413 Gorsuch Ave.

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred 50 yrs. --- mos. --- ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Married

6 If married, name of HUSBAND Elene W. Gates.

7 DATE OF BIRTH (month, day, and year) July 18, 1857.

8 AGE Years 70 Months 8 Days 10 IF LESS than 1 day.....hrs. or.....min.

### 9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship joiner

(b) General nature of industry, business, or establishment in which employed (or employer) Tolchester Co.

(c) Name of employer

### 10 BIRTHPLACE (city or town)

(State or country) Norfolk, Va.

11 NAME OF FATHER Thomas L. Gates.

12 BIRTHPLACE OF FATHER (city or town) Maryland.

13 MAIDEN NAME OF MOTHER Mary E. Mears.

14 BIRTHPLACE OF MOTHER (city or town) Virginia.

15 Informant Elene W. Gates (wife)  
(Address) 1413 Gorsuch Ave.

16 Filed G. HAMFSON JONES, M. D.  
RAA Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic disease of the heart.

(duration) yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.  
(Signed) [Signature] M. D.  
(Coroner)

2/80, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Tolchester Co. Pier 16 Light St.

Former or usual residence March 28, 1928.

### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cemetery Date of Burial Mar 31 1928

### 20 UNDERTAKER

John F. Denny ADDRESS 715 Light

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32295

## CERTIFICATE OF DEATH.

47 E 32295

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1719 Palapen St. 23 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Hirschbaker(a) RESIDENCE NO. 1719 Palapen St. 23 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 2 mos. 25 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

1 Color or Race

5 Single, Married, Widowed, or Divorced (write the word)

Female White Singlea If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

b DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.Jan 4 1882  
46 2 25

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14

Informant  
(Address)

15

1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1928, to Mar 29, 1928  
that I last saw him alive on Mar 25, 1928and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia of Breast

CONTRIBUTORY

(Secondary)

(duration) 2 yrs. 2 mos. 24 ds.(duration) .....yrs. ....mos. 2 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death

Date of Jan 1928

Was there an autopsy

What test confirmed diagnosis

(Signed)

Date Mar 29, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Western Cem March 3, 1928  
A. Howard Evans 388 Foster

HEALTH DEPARTMENT—CITY OF BALTIMORE

32296

CERTIFICATE OF DEATH.

90 E 32296

1-PLACE OF DEATH

City of BALTIMORE: (No. 725 Brannan Court.

St. Ward

2-FULL NAME

Sarah Whiteman. (C)

(a) RESIDENCE NO. 725 Brannan Court.

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 85

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)  
Female. Colored Married.

6a If married, ~~XXXXXXXXXX~~  
~~XXXXXXXXXX~~  
(or) WIFE of

Thomas Whiteman. (C)

6 DATE OF BIRTH (month, day, and year)

Do not know.

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town)

(State or country)

Virginia.

10 NAME OF FATHER

Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Do not know.

14 Informant Joseph Turner. (C)

(Address) 725 Brannan Court.

15 Filed G. HAMMON JONES, M. D. Registrar

1928

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

3/30/28 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt Auburn CT April 2 1928

20 UNDERTAKER

ADDRESS

S. A. Brown & Son 108 W. 7th St

32297

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Registered No. ....

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 411 W. Annapolis St. 71-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barth F. Jones

(a) Residence No. 411 W. Annapolis St. 71-31 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

SEX Female 4-COLOR OR RACE Colored 5-Single, Married, Widowed, or Divorced. Widowed (Write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day and year) 1886

AGE 74 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

### OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

BIRTHPLACE (city or town) MD (State or Country)

PARENTS.

10-NAME OF FATHER Hanson Huffield

11-BIRTHPLACE OF FATHER (city or town) MD (State or Country)

12-MAIDEN NAME OF MOTHER Charlotte Johnson

13-BIRTHPLACE OF MOTHER (city or town) MD (State or Country)

14- (Informant) Idorance Palm  
(Address) Sand St. Hamaroneck NY

15- CHAMBERLAIN  
Filed 31 1920 Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 27 1920

17- I HEREBY CERTIFY, That I attended deceased from March 15 1920 to March 27 1920 that I last saw him alive on March 27 1920 and that death occurred, on the date stated above, at 100 years. The CAUSE OF DEATH\* was as follows:

Pneumonia Lobes

### CONTRIBUTORY

18-Where was disease contracted Home  
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician's Report  
(Signed) Dr. J. H. Brown M. D.

March 27 1920 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL MT Auburn DATE OF BURIAL, MAY 31 1920

20-UNDERTAKER J. H. Brown & Son ADDRESS 118 W. Montgomery



32298

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 ✓ E 32298  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 Mt. Calhoun St. 14-20 WARD)

## 2. FULL NAME John Gray

(a) RESIDENCE NO. 1924 Mt. Calhoun St.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1894

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER John Gray

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

1924

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1928, to March 28th, 1928.

that I last saw him alive on March 28th, 1928.

and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma rectum

(duration)

yrs.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of 1922

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1928

(Address)

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1027

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32299

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

806 N. Spring

ST. 10-13 WARD)

## 2-FULL NAME

Joseph Hughes

(a) RESIDENCE NO.

806 N. Spring St.

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

M

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced, (write the word)

Married

If married, widowed, or divorced

HUSBAND of or) WIFE of

Annie Hughes

DATE OF BIRTH (month, day, and year)

? 1887

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

41

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

Whole Sale Flour Co.

(c) Name of employer

Ruhel.

BIRTHPLACE (city or town) (State or country)

Cambridge Maryland

10 NAME OF FATHER

Joseph Hughes Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cambridge Maryland

12 MAIDEN NAME OF MOTHER

Willie P. Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Cambridge Maryland

14

Informant (Address)

Annie Hughes 806 N. Spring St.

15

File

31-1926

C. HAMPSON JONES, Registrar

H. H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 28 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 26, 1928, to Mar. 28, 1928,

that I last saw him alive on Mar. 28, 1928,

and that death occurred, on the date stated above, at 3:20 A. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia, upper middle lobe right lung, lower lobe left lung.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Acute dilatation heart

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Calvin B. LeCompte, M. D.

, 19

(Address)

814 N. Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Asbury Cemetery

DATE OF BURIAL

Mar. 31, 1928

20 UNDERTAKER

Edward Bryan

ADDRESS

1631 Orleans St

1733  
32300

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32300

## CERTIFICATE OF DEATH.

38

## 1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

## CITY OF BALTIMORE: (No.)

ST. 7-4 (WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

William Jones

## (a) RESIDENCE No.

238 S. Harrison St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 4 mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Black

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

1-30-27

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

4

29

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Ind -

10 NAME OF FATHER

Wm Jones

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ind -

12 MAIDEN NAME OF MOTHER

Mary Stevens

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ind -

4 Informant  
(Address)

Records -

5 1928

C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar - 29 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar. 3 1928, to Mar. 29 1928,  
that I last saw him alive on Mar. 29 1928,  
and that death occurred, on the date stated above, at 12<sup>20</sup> P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia, lobar for 1 month  
(Syphilis, congenital)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY  
(Secondary)Bilateral otitis media  
(duration) yrs. 15 ds.18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? A neg. Blood Wassermann  
(Signed) J. J. Bennett M. D.

Mar. 27 1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Arbury cemetery

DATE OF BURIAL

March 31 1928

20 UNDERTAKER

Edward Bryan

ADDRESS

Orleans St

32301

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32301

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2419 Hudson Pl ST. 1-3 WARD)2. FULL NAME Jackson Dotes

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 2419 Hudson Pl ST. 1-3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX M 4 COLOR OR RACE col 5 Single, Married, Widowed, or Divorced, (write the word) widowedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) 1865

AGE Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) va10 NAME OF FATHER Samuel Dotes11 BIRTHPLACE OF FATHER (city or town)  
(State or country) va12 MAIDEN NAME OF MOTHER Alvin Wright13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) vaInformant Willie Davis(Address) 1623 N. Baltimore St.1928 C. THOMPSON JONES, M. D.

Filed

19

Registered

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 192817 I HEREBY CERTIFY That I attended deceased from March 1, 1928 to March 29, 1928, that I last saw him alive on March 29, 1928 and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) acute Nephritis yrs. mos. ds.

18 Where was disease contracted

if not at place of death? unknownDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Physician's Exam.(Signed) G. A. Hall M. D.19 (Address) 426 B 23rd St.

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Northumbland St. va

20 UNDERTAKER

ADDRESS

Robert T. Williams 1515 McElday St



32302

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32302

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

JOHNS HOPKINS HOSPITAL

## 2. FULL NAME

Ophraim Tildon

(a) RESIDENCE NO.

1320 Argyle Ave

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 17-24 WARD

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Black

Child

(If married, widowed, or divorced HUSBAND of (or) WIFE of)

DATE OF BIRTH (month, day, and year)

12/26/27

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Wm. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Hilda Tildon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

Informant (Address)

Records

1-1928

C. HAMISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar-28 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar-26 1928, to Mar-28 1928,

that I last saw him live on Mar-28 1928,

and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH\* was as follows:

Congenital syphilis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

Blood Wassermann

(Signed)

J. B. Bennett

M. D.

Address

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

MAR 30 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32303

## CERTIFICATE OF DEATH.

E 32303

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1902 Semmon St. 20-28 Ward 8)2-FULL NAME Maureen McDonald(a) RESIDENCE NO. 1907 Semmon St. 20-28 Ward 8(Usual place of abode)  
Length of residence in city or town where death occurred 1 yrs. 7 mos. 19 ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Infanta If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) Aug 11 1926AGE Years 1 Months 7 Days 19 IF LESS than  
1 day.....hrs.  
or.....min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto  
(State or country)10 NAME OF FATHER Celest McDonald11 BIRTHPLACE OF FATHER (city or town) Mesa  
(State or country)12 MAIDEN NAME OF MOTHER Maria Whately13 BIRTHPLACE OF MOTHER (city or town) Ind  
(State or country)14 Informant Celest McDonald  
(Address) 1902 Semmon1-1326 G. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/2817 I HEREBY CERTIFY, That I attended deceased from  
3/26/28 to 3/30/28, 1928,  
that I last saw him alive on 3/30/28, 1928,  
and that death occurred, on the date stated above, at 4:25 A.M.  
The CAUSE OF DEATH\* was as follows:measles (Hemolytic)CONTRIBUTORY (duration) yrs. mos. 12 ds.  
(Secondary) Later Pneumonia(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann  
(Signed) Samuel J. Ferry, M. D.  
4/30/1928 (Address) 110 W. Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louisa Platan Date of Burial Mar 31 192820 UNDERTAKER Funeral Co. of Baltimore ADDRESS 1906 Calver

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 32304

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludwik Twardowski

(a) RESIDENCE NO. 613 S. Bond Street St. 2-4 Ward

(If non-resident give city or town and State)

(Usual place of abode)  
Length of residence in city or town where death occurred 23 yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug, 1889

AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland  
(State or country)

10 NAME OF FATHER Zukarz Twardowski

11 BIRTHPLACE OF FATHER (city or town) Poland  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland  
(State or country)

14

Informant (Address) Joseph Twardowski  
613 S. Bond Street

15 C. HAMPTON JONES, M. D.  
Registrar

16 1928

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Frac. Seg & ribs-Prob. frac of Skull  
Accident-Struck vby automobile  
Caroline & Madison Sts.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) John B. Jones M. D.  
(Coroner)

3/30/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

ST, Stanislaus Cem April 2 1928

20 UNDERTAKER

George A Weber 2205

ADDRESS Bank Street

George A. Weber

32305

## HEALTH DEPARTMENT—CITY OF BALTIMORE 32305

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 N. Gilman ST. WARD 14-27)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Irma Sybil Greene(a) RESIDENCE No. 319 N. Gilman ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word)

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 3/23/28AGE Years Months Days If LESS than 1 day, hrs. or min. 7

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore Md.10 NAME OF FATHER Joseph Greene11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.12 MAIDEN NAME OF MOTHER Mary Walker13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.4 Informant (Address) Mary Walker Greene

5 1928

HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 30 1928

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1928, to March 29, 1928, that I last saw her alive on March 29, 1928, and that death occurred, on the date stated above, at 4:53 P. m. The CAUSE OF DEATH\* was as follows:Premature Birth.  
(about 7 months)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) J. T. Shelton, M. D.(Address) 1305 N. Gilman St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

W. H. Brown & Son 10812 Mont



32306

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32306

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home & Infirmary* ST. *1-2* WARD)2-FULL NAME *Mrs Carrie Endress*(a) RESIDENCE NO. *141 S. Lenwood Ave* ST. *1* WARD(Usual place of abode)  
Length of residence in city or town where death occurred *49* yrs. *3* mos. *26* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*If married, widowed, or divorced HUSBAND of (or) WIFE of *the late August G. Endress*DATE OF BIRTH (month, day, and year) *Dec. 4 1878*AGE Years *49* Months *3* Days *26* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Keeper*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

BIRTHPLACE (city or town) *Balto. Md.* (State or country)10 NAME OF FATHER *John Goeller*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Mary Pfeifer*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Rose Eva Endress* (Address) *141 S. Lenwood Ave.*15 *1928* C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 30 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar. 21 1928* to *Mar. 30 1928*, that I last saw him alive on *Mar. 30 1928*, and that death occurred, on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Acute cardiac dilatation*CONTRIBUTORY (Secondary) *Myocarditis* (duration) yrs. mos. *1* ds.18 Where was disease contracted if not at place of death? *at home* (duration) yrs. mos. ds.Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical Exam*(Signed) *W. Brannigan* M. D.19 (Address) *Church Home & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Holy Redeemer Cemetery*

20 UNDERTAKER

*Lilly & Ziehl Inc.*

DATE OF BURIAL

*April 2 1928*

ADDRESS

*403 S. W. 15*

32307

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32307

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

BALTIMORE CITY HOSPITAL

ST.,

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Otto Deringer

## (a) RESIDENCE No.

203 S. 2nd

ST.,

26

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

Married, widowed, or divorced  
HUSBAND of  
or) WIFE of

Rosa Deringer

## DATE OF BIRTH (month, day, and year)

3

1875

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

53

52

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Salvage

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Germany

## 10 NAME OF FATHER

Francis Deringer

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Marie Deringer

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

Informant  
(Address)

Records

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29/1928.

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 27, 1928, to Mar. 29, 1928

that I last saw him live on Mar. 29, 1928.

and that death occurred, on the date stated above, at 12:00 A.M.

The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic & acute  
arteriosclerosis, Hypertension  
Aneurysm of the aorta

(duration) yrs. 7 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. Stephen Boyd, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Sacred Heart Cemetery

April 2nd, 1928

## 20 UNDERTAKER

## ADDRESS

Lilly &amp; Zeller Inc

1038 North

32308

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32308

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if of foreign birth

(If non-resident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced, (write the word)

If married, widowed or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

15

File

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
March 22, 1928, to March 28, 1928  
that I last saw him alive on March 28, 1928.

and that death occurred, on the date stated above, at 10:50 m.

The CAUSE OF DEATH\* was as follows:

Acute Cordiac Dilatation

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) ? yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE 32309

32309

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 66-10-Resurrection ST., 47-55 WARD)2. FULL NAME Rosmond Louis McMahon(a) RESIDENCE NO. 66-10-Resurrection ST., 47-55 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_DATE OF BIRTH (month, day, and year) Oct-1-1925AGE Years 2 Months 5 Days 29 If LESS than 1 day, 28 hrs. or 0 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child(b) General nature of industry, business, or establishment in which employed (or employer) 000(c) Name of employer 000BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Rosmond L. McMahon11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.12 MAIDEN NAME OF MOTHER May E. Mayes13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.14 Informant Rosmond L. McMahon (Address) 66-10-Resurrection St.

31-1928

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1925

17

I HEREBY CERTIFY, That I attended deceased from 3/29/25 to 3/29/25, 1925, that I last saw him alive on 3/29/25, 1925, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho PneumoniaCONTRIBUTORY (Secondary) Heart Enlargement (duration) 12 yrs. 0 mos. 0 ds. Pneumonia (duration) 9 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Culture(Signed) Rosmond L. McMahon M. D. (Address) 5912 Flat Heights Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Green Cove DATE OF BURIAL April 19 2520 UNDERTAKER H. M. Cook ADDRESS 501 E. St. Ave.



HEALTH DEPARTMENT—CITY OF BALTIMORE

32310

E 32310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital

St. 25-75 Ward)

2-FULL NAME

Rea V. Foranger

(a) RESIDENCE NO.

910 Potomac Ace., Brooklyn Md.

St. Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

female

white

single

6 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

7 DATE OF BIRTH (month, day, and year)

Dec 12/ 27

8 AGE

Years

Months

Days

IF LESS than

3

27

1 day.....hrs.  
or.....min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

10 BIRTHPLACE (city or town)

(State or country)

Maryland

11 NAME OF FATHER

Lynn Foranger

12 BIRTHPLACE OF FATHER (city or town)

(State or country)

Penna

13 MAIDEN NAME OF MOTHER

Mamie Sonders

14 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

15

Informant

Father

(Address)

910 Potomac St

16

FILE

1928

17

REGISTERED

RKM

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 30/28

17

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said (Inquest, au-

inquiry

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobular Pneumonia

(Autopsy)

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Pertussis?

(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

M. D.

3/31/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs.,.....mos.,.....ds. In the

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Schwartz Cemetery

3/31/28

20 UNDERTAKER

William Cook

ADDRESS

502 E. North

32311

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32311

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

65 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

(If married, widowed, or divorced HUSBAND of (or) WIFE of)

DATE OF BIRTH (month, day, and year)

Aug 7 1962

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

7

23

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Maryland.

10 NAME OF FATHER

Samuel J. Lopez

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sarah A. Hise

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

Informant (Address)

Records Union Memorial Hospital City.

R 31 1928

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar-30-1928

17

I HEREBY CERTIFY, That I attended deceased from

3/21

1928, to

3/30

1928,

that I last saw him alive on

3/30

1928,

and that death occurred, on the date stated above, at

6:30 A.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma sigmoid Colon

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes

Date of

3/24/28

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

Arthur W. W. M. D.

19

(Address)

Union Memorial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Union Memorial Hospital

May 31 1928

UNDERTAKER

ADDRESS

Stewart Memorial Hospital

V. B. S. S.

7-12-23-MAT-500 Bk.  
E 32312  
2349

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32312

CERTIFICATE OF DEATH.

113

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.)

JOHNS HOPKINS HOSPITAL

ST. 1-1 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Richard Sleshield

(a) RESIDENCE NO.

3109 Elliott

ST. WARD

City

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Male

White

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

5-14-27

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

10

15

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Ind -

10 NAME OF FATHER

Richard Sleshield

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind -

12 MAIDEN NAME OF MOTHER

Ruth Curney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind -

Informant (Address)

Records -

MAR 31 1928

TAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar - 29 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar - 22, 1928, to Mar - 29, 1928, that I last saw him live on Mar - 29, 1928, and that death occurred, on the date stated above, at 8:45 P. M.

The CAUSE OF DEATH\* was as follows:

Acute ~~disenteritis~~ enteritis (Type unspecified - culture neg. for B. dysenteriae).

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

No

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

J. B. Bennett

Mar 30, 1928

(Address)

Johns Hopkins Hospital

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Schuyler Cemetery

20 UNDERLAYER

J. J. Moran

ADDRESS

1928

3000 E. Baltimore

32313

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32313

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3964 Wilson Ave.

2. FULL NAME Joseph B. Croghan

(a) RESIDENCE NO. 3964 Wilson Ave.  
(Usual place of abode)Length of residence in city or town where death occurred Lifetime  
yrs. mos.

ST. WARD

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)ST. WARD  
(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single, Married, Widowed,  
or Divorced, (write the word)  
Male White MarriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Anne C. Croghan

DATE OF BIRTH (month, day, and year) Sept. 28th/ 1884

AGE Years Months Days If LESS than  
1 day, hrs  
or min.  
43 6 2

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Clerk.(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Baltimore

(c) Name of employer Post Office,

BIRTHPLACE (city or town)  
(State or country) Baltimore Md.

10 NAME OF FATHER Michael J. Croghan

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Moran

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Ireland.Informant Anne C. Croghan.  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 30th? 28.

I HEREBY CERTIFY, That I attended deceased from  
Feb. 15 1928, to Mar 30 1929.

that I last saw him alive on Mar 30 1929

and that death occurred, on the date stated above, at 104, m

The CAUSE OF DEATH\* was as follows:

Chronic nephritis  
(duration) 6 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. White, M. D.

19 (Address) 1810 E. 11th St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Cathedral Cemetery.

DATE OF BURIAL

4/2.28.19

ADDRESS

Filed  
APR 1 1928

C. HAMPTON JONES, M. D.

20 UNDERTAKER

J. H. White, M. D.  
1810 E. 11th St.



32314

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32314

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church House & Infirmary* ST. *8-16* WARD)2-FULL NAME *Baby Lil Russell*(a) RESIDENCE NO. *2406 E Federal* ST., WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Balto. Md.*10 NAME OF FATHER *Hynd F. Russell*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto. Md.*12 MAIDEN NAME OF MOTHER *Lillian M. Taylor*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *Mr. Hynd F. Russell*  
*2406 E Federal*

15

1 1928

C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/31/1928*

17

I HEREBY CERTIFY, That I attended deceased from *4:33 P.M., 3/31, 1928*, to *9:15 P.M., 3/31, 1928*.that I last saw her alive on *3/31/1928*,and that death occurred, on the date stated above, at *9:15 P.M.*

The CAUSE OF DEATH\* was as follows:

*Prematurity*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *St. Louis*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Dr. Grand Jones*, M. D.3, 1928 (Address) *Church House & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Baltimore Cemetery*  
*Henry Wood**Md. St. 1928*  
*107 E. Bay St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32315

E 32315

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 Brooks Lane

ST. 13-54 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Diana Jacoby

(a) RESIDENCE NO. 832 Brooks Lane.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred Lifetime mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)  
Female White Singlemarried, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 20th. 1862

AGE Years Months Days If LESS than 1 day, hrs. or min.  
65 4 10

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER Jacob Jacoby

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Zilla Hayman

13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)

Informant Miss. Altman

(Address) 832 Brooks Lane

Filed 1928

G. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30th. 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1928, to March 30, 1928, that I last saw him alive on March 29, 1928, and that death occurred, on the date stated above, at 5:30 A. M.  
The CAUSE OF DEATH\* was as follows:Myocarditis as lesion  
sclerosis hyper tension

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Toxicemia, Terminal pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friederwald, M. D.  
, 19 (Address) 1013 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oheb Shalom Cem.

DATE OF BURIAL

4/1/1928

20 UNDERTAKER

David Sondheim  
ADDRESS 118-20 W. Mt. Royal Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32316

CERTIFICATE OF DEATH.

E 32316

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Catherine Smith

(a) RESIDENCE NO. 136 Winter Ave., Catonsville St., 4d Ward

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. / ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) July 28/27

8 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
3 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....none  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9 BIRTHPLACE (city or town).....Md.  
(State or country)

10 NAME OF FATHER Theodore Smith

11 BIRTHPLACE OF FATHER (city or town).....Md  
(State or country)

12 MAIDEN NAME OF MOTHER Viola Scott

13 BIRTHPLACE OF MOTHER (city or town).....Md.  
(State or country)

14 Informant Mother  
(Address)

15 1928 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pertussis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. [Signature] M. D.  
(Coroner)

3/31/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death!.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Evergreen Catonsville 3-31-28  
20 UNDERTAKER Joseph A. Lively ADDRESS 409 N. Mount St

32317

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 32317

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4005 Hamilton Ave 7-4)

Registered No. ....

## 2-FULL NAME

Lawrence V. McShane

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) Residence No.

4005 Hamilton Ave

Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

## SEX

Male

## 4-COLOR OR RACE

White5-Single, Married, Single  
Widowed,  
or Divorced,  
(Write the word.)6-If married, widowed, or divorced  
HUSBAND of (or) WIFE ofchild

7-DATE OF BIRTH (month, day and year)

March 16-28

## 8-AGE

If LESS than 1 day,

yrs.

mos. 15 ds.

hrs. or min.?

## 9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer).

(c) Name of employer.

10-BIRTHPLACE (city or town)  
(State or Country).10-NAME OF  
FATHER,11-BIRTHPLACE  
OF FATHER (city or town)  
(State or Country),12-MAIDEN NAME  
OF MOTHER,13-BIRTHPLACE  
OF MOTHER (city or town)  
(State or Country),

14-

(Informant)

(Address)

15-

7 1928

C. HAMMOND JONES, M. D.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

March 31/28

17- I HEREBY CERTIFY, That I attended deceased from

Mar 30 1928 to Mar 31 1928that I last saw him alive on Mar 30 1928and that death occurred, on the date stated above, at 1204 m.

The CAUSE OF DEATH\* was as follows:

Jaundice - new born(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

Probable Hemorrhagic Coma  
non bile duct (Duration) yrs. mos. ds.

18-Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. B. Brown M. D.  
3/31 1928 (Address) 914 E. Brooke\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

New Cathedral3-8-28 1928L. J. Orick6405 Leffler Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32318

## CERTIFICATE OF DEATH.

E 32318

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 126 W Randal ST. 23-32 WARD)2-FULL NAME Gloria Lee Spiker

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 126 W Randal

(Usual place of abode)

ST., \_\_\_\_\_

WARD \_\_\_\_\_

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX M4 COLOR OR RACE W5 Single, Married, Widowed, or Divorced, (write the word) SingleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) Jan 5, 1928

AGE

Years

Months

Days 25If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) Baltimore Md10 NAME OF FATHER Leroy Spiker11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Md12 MAIDEN NAME OF MOTHER Viola Kiser13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Md

14

Informant  
(Address) Leroy Spiker  
126 W Randal St

15

1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1928

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1928, to March 30, 1928,  
that I last saw her alive on March 30, 1928,  
and that death occurred, on the date stated above, at 4:25 P m.

The CAUSE OF DEATH\* was as follows:

Bronchio Pneumonia12 hours (duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_\_ yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death? at place of deathDid an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Physical Diagnosis(Signed) Allen W. Kelly

M. D.

, 19 (Address) 1412 Light St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Cedar Hill

DATE OF BURIAL

April 2 1928

20 UNDERTAKER

ADDRESS

Wm Cook & Co

32319

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32319

1-PLACE OF DEATH

TY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

length of residence in city or town where death occurred

### PERSONAL AND STATISTICAL PARTICULARS

EX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

C. HAMMOND JONES, M. D. Registrar

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1928, to March 31, 1928, that I last saw him alive on March 31, 1928, and that death occurred, on the date stated above, at 1:45 a.m. The CAUSE OF DEATH\* was as follows:

Respiratory failure - Primitive Baby - at 7 mo. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sepsis - (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? none

What test confirmed diagnosis? clinical

(Signed) Frank D. Jones, M. D. 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

UNDERTAKER

DATE OF BURIAL

ADDRESS

502 E. North

E 32320

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44 E 32320

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5611 Belle Vista ave. 27-42)

2-FULL NAME *Annie E Jones*

(a) RESIDENCE No. 5611 Belle Vista ave.

(Usual place of abode)  
Length of residence in city or town where death occurred 51 yrs. 5 mos. 8 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

If married, widowed, or divorced HUSBAND of (or) WIFE of

*Charles B Jones*

DATE OF BIRTH (month, day, and year)

*Oct 1 - 1876*

AGE

Years

Months

Days

*51*

*5*

*8*

If LESS than 1 day, hrs or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House Work*

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*James B Balorg*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore*

12 MAIDEN NAME OF MOTHER

*Winifred Conroy*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore*

14

Informant (Address)

*Charles B Jones*  
*5611 Belle Vista ave*

15

1928

*C. HAMPSON JONES, M. D.*

Registrar

*Henry Lutz*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-29-95*

17

I HEREBY CERTIFY That I attended deceased from 1-20-25 to 3-29-25 that I last saw him alive on 3-29-25 and that death occurred, on the date stated above, at 19 25 m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Pancreas & Liver*

CONTRIBUTORY (Secondary)

*Cardiovascular*

18 Where was disease contracted if not at place of death?

*unknown*

Did an operation precede death?

*No*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Findings*

(Signed)

*W. H. R. Jones, M. D.*

(Address)

*300 North Ave*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery*

*April 2 1928*

UNDERTAKER

*Henry Lutz*  
*22 Broadway*

32321

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32321

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Melvale*)

## 2. FULL NAME

*Columbus O'Donnell Lee*

(a) RESIDENCE NO. *Melvale, Baltimore*  
(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs. mos. ds.

ST. *12th* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

If married, widowed, or divorced

HUSBAND of *Hannah A. T. Lee*  
WIFE of

DATE OF BIRTH (month, day, and year) *8th Nov. 1852*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*75*

*4*

*23*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Pres Universal*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Machine Co*

(c) Name of employer

*until Fall of 1927*

BIRTHPLACE (city or town) (State or country)

*Frederick Co. Md.*

10 NAME OF FATHER

*Thomas Sim Lee*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

*Josephine O'Donnell*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*Frederic C. Lee*

15

1928

*G. HAMPSON JONES, M.D.*

Registrar

## CERTIFICATE OF DEATH.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 31st 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 1st*, 1928, to *March 31st*, 1928, that I last saw him alive on *March 28*, 1928, and that death occurred, on the date stated above, at *8-9* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction*

CONTRIBUTORY (Secondary)

(duration) *0* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *to* Date of

Was there an autopsy? *to*

What test confirmed diagnosis? *myo & sygn*  
(Signed) *J. A. Chubb*, M. D.

(Address) *1307 W. Calvert St*  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*St. Charles Cathedral Cmr*

20 UNDERTAKER

*Henry W. Jenkins, Sons & Co*

DATE OF BURIAL

*4-2-28*

ADDRESS

*Richards  
McCullers*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32322

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital, Baltimore, Md. ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R. Mulligan

(a) RESIDENCE No. 625 East Mahanoy Ave., Girardville, Pa.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

yrs.

mos. 11

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) January 4, 1904

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	2	26	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Wiper

(c) Name of employer

BIRTHPLACE (city or town) Girardville, Pa.  
(State or country)

10 NAME OF FATHER Joseph Mulligan

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania  
(State or country)

12 MAIDEN NAME OF MOTHER Mary Monaghan

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania  
(State or country)Informant U.S. Marine Hospital records  
(Address)

Filed

31 1928

HARRISON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Friday March 30, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1928, to March 30, inc. 1928

that I last saw him alive on March 30, 1928

and that death occurred, on the date stated above, at 11:55 Pm.

The CAUSE OF DEATH\* was as follows:

Diabetes mellitus

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY Pulmonary Tuberculosis;  
(Secondary) Pneumonia T.B. 8 months  
Pneumonia (duration) yrs. mos. 2 ds.18 Where was disease contracted Not known  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood and Urin exams.

(Signed)

, 19

(Address)

U.S. Marine Hospital, Baltimore, Md.

\*State the Disease Causing Death, or in death from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Girardville, Penna.

March 31, 1928

UNDERTAKER

E. Leroy Stiffler

ADDRESS

125 E. North Ave.

12148  
E 32323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 E 32323

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JONES HOPKINS HOSPITAL

2. FULL NAME

Walter Pond

74

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

46 S Wootton Ave

ST.

WARD

Rochester N.Y.

(Usual place of abode)  
Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

7-13-60

AGE

67 Years

Months

Days

If LESS than 1 day, hrs. or min.

68

8

17

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Police Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Fla -

10 NAME OF FATHER

Frank Pond

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mass -

12 MAIDEN NAME OF MOTHER

Fannie Herbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Chic

14 Informant (Address)

Records -

Filed

1928 JAMES H. JONES, M. D.

R. H. Jones, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 30 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 16, 1928, to Mar - 30, 1928,

that I last saw him live on Mar - 30, 1928,

and that death occurred, on the date stated above, at 2 37 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia  
Bilateral

CONTRIBUTORY (Secondary)

(duration)

Yrs.

Mos.

Ds.

Recto-vesical Fistula

(duration)

Yrs.

Mos.

Ds.

2

18 Where was disease contracted if not at place of death?

Did an operation precede death?

yes

Date of 3-29-28

Was there an autopsy?

yes

What test confirmed diagnosis?

(Signed)

J. H. Jones

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Syracuse N.Y.  
Undertaker Joseph Abrams

DATE OF BURIAL

3/30/28

ADDRESS

221 Bay

32324

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32324

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sinai Hospital* ST. *15-58* WARD)2-FULL NAME *Mr. Morris Lee Boie*(a) RESIDENCE NO. *4215 Park Heights Ave*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred *35* yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? *20* yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male white**married*

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Sarah DeBois*DATE OF BIRTH (month, day, and year) *unknown*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*61*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Russell*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Russell*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Russell*Informant  
(Address)*Mr. Jaffie**4215 Park Heights Ave*15  
Filed

APR 1 - 1928

JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/31/28*

17

I HEREBY CERTIFY, That I attended deceased from  
*3/29/*, 19 *28*, to *3/31/*, 19 *28*.that I last saw him alive on *3/31/*, 19 *28*.and that death occurred, on the date stated above, at *49* m.

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Pulmonary edema*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*Henry Ginsburg*

M. D.

19 (Address)

*Sinai Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Heaven Southern Cal**3/31* 19 *28*

UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. 1st St.*

E 32325

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32325

## 1-PLACE OF DEATH

City of BALTIMORE:

Maryland General Hospital (Ward)

## 2-FULL NAME

Henry Goldsmith

(a) RESIDENCE NO.

3912 Gwyn Oak Ave.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. if of foreign birth? 38 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. Lena Green

6 DATE OF BIRTH (month, day, and year)

4-15-1875

7 AGE

Years

Months

Days

52

11

16

IF LESS than 1 day.....hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Moses Goldsmith

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Mary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

Hospital Records

15 Filed

1928

C. H. Jones

Registrar

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

3-31-28

17

I HEREBY CERTIFY, That I attended deceased from

3-27-28, 19, to 3-31-28, 19,

that I last saw him alive on 3-31-28, 19,

and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH\* was as follows:

Duodenal ulcer

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of 3-29-28

Was there an autopsy? no

What test confirmed diagnosis? Chinese

(Signed) C. C. Zimmerman, M. D.

3/31, 1928 (Address) Md. General Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

Date of Burial

Hehren Rosedale

4/1

1928

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. 28th St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32326

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3910 Lynwood Ave ST. 28-64 WARD)

## 2. FULL NAME

Fannie E. Dail

## (a) RESIDENCE No.

(Usual place of abode)

3910 Lynwood Ave ST.

WARD

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) SingleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofThomas J. DailDATE OF BIRTH (month, day, and year) Sept 29-1843AGE Years 84 Months 6 Days 1 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Maryland  
Cambridge

## 10 NAME OF FATHER

Thomas J. Dail11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Cambridge  
Maryland

## 12 MAIDEN NAME OF MOTHER

Fannie Thompson13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Frederick  
Maryland14 Informant  
(Address)J. Howard Dail  
3910 Lynwood Ave

15 Filed

1928C. HAMMOND JONES, M. D.  
R. H. K. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 19 2817 I HEREBY CERTIFY, That I attended deceased from Mar 26 28 to Mar 30 19 28, that I last saw him alive on Mar 30 19 28 and that death occurred, on the date stated above, at 3:50 P. m. The CAUSE OF DEATH\* was as follows:  
Bronchial PneumoniaCONTRIBUTORY (duration) yrs. mos. 2 ds. Auto Bronchitis  
(Secondary) (duration) yrs. mos. 3 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physicil signs  
(Signed) Sam E. Hinkle M. D.\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)  
700 St. W. Ave19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Green Mount CemApr 2 19 28

20 UNDERTAKER

Harry W. Chlen1844  
W. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32327

## CERTIFICATE OF DEATH.

90 E 32327  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3332 Lyndale Ave

2-FULL NAME Laura Virginia Bell

(a) RESIDENCE NO. 3332 Lyndale Ave

(Usual place of abode)

St. Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female

white

widow

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

James B. Bell 1867

6 DATE OF BIRTH (month, day, and year)

Mar 16/1867

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

61

0

14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

none

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

At home

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER Cornelius Reynolds

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

Bessie Bell (Daughter)

3332 Lyndale Ave

15

Filed

1928 G

HARRISON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 30/23

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.) and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

(Address)

3/31/28 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death.....yrs.,.....mos.,.....ds.

In the

State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL

20 UNDERTAKER

ADDRESS



E 32329

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32329

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Harlem Ave.)

## 2-FULL NAME

(a) RESIDENCE. No. 1402 Harlem Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Cauc

Married

a If married, widowed, or divorced HUSBAND or (or) WIFE of

Rosa Winbush

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

1928

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY That I attended deceased from March 18, 1928, to March 24, 1928, that I last saw him alive on March 28, 1928, and that death occurred, on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH\* was as follows:

Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Coleman, M. D.

(Address) 2039 McCulloch

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32330

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 N. Gay ST. 10-14 WARD)

### 2-FULL NAME

Harry S. Kelly

(a) RESIDENCE No. 1223 N. Gay ST. 10-14 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 5 mos. 5 ds.

REGISTERED NO. 10-14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Kelly

DATE OF BIRTH (month, day, and year) Aug 16, 1864

AGE Years 63 Months 7 Days 15 If LESS than 1 day, hrs or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) MD

10 NAME OF FATHER John Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Julia Tall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant Mrs Ida S. Kelly (Address) 1223 N. Gay St

15 Filed 1928 19 22 DR. H. J. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31, 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar. 26, 1928, to Mar. 31, 1928, that I last saw him alive on Mar. 30, 1928, and that death occurred, on the date stated above, at 11:35 a. m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Congestive

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby M. D.

3/31/1928 Address 1223 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Tolchester MD

DATE OF BURIAL

20 UNDERTAKER Wm. Cook

ADDRESS 512 E. North Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32332

## CERTIFICATE OF DEATH.

32332

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3535 E. Farmmount St. Ward 6-37)2-FULL NAME Mrs. F. Butler(a) RESIDENCE NO. 3535 E. Farmmount Ward 6

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah C. Butler6 DATE OF BIRTH (month, day, and year) 18707 AGE Years 54 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Pa10 NAME OF FATHER John Butler11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa12 MAIDEN NAME OF MOTHER Sarah Jones13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14

Informant (Address) Charles J. Butler  
3407 Bonh St

15

Filed.....rs

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 192817 I HEREBY CERTIFY That I took charge of the remains described above, held a Inquest (Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said Inquest and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

AC Indigestion  
Errors of diet  
(duration) yrs. mos. ds. 1 hr.

CONTRIBUTORY (Secondary)

mar Cardiac Asthenia  
(Signed) J. C. Jones M. D.  
(Address) 14316 B. May

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial

Western Cem 4/2 192820 UNDERTAKER W. H. Cook ADDRESS 502 E. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32333

## CERTIFICATE OF DEATH

90 E 32333

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 915 Forrest St. 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sabina M. Snyder(a) RESIDENCE NO. 915 Forrest St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 6, 1883

7 AGE Years Months Days IF LESS than 1 day hrs. or min.

44 4 25

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator 086  
(b) General nature of industry, business, or establishment in which employed (or employer) in Shoe Factory  
(c) Name of employer9 BIRTHPLACE (city or town) Balto  
(State or country)10 NAME OF FATHER Joseph J. Snyder11 BIRTHPLACE OF FATHER (City or town) Balto Md  
(State or country)12 MAIDEN NAME OF MOTHER Edonia Karmeyer13 BIRTHPLACE OF MOTHER (city or town) Balto Md  
(State or country)14 Informant Mrs. Anna Snyder  
(Address) 915 Forrest St15 Filed 1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 192817 I HEREBY CERTIFY, That I attended deceased from July 1st, 1927, to March 31, 1928, that I last saw her alive on March 31, 1928, and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH\* was as follows:

Valvular Heart DiseaseCONTRIBUTORY Ascites  
(Secondary)(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Clinical symptoms(Signed) W. H. Pearce M. D.3-31-1928 (Address) Paul & Ruston St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial April 5, 192820 UNDERTAKER Henry Stock Inc ADDRESS 1301 E. Gay St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32334

## CERTIFICATE OF DEATH.

REGISTERED NO. 101-201-E 32334

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 576 Walnut St. 17-24 Ward)

## 2-FULL NAME John W. Oliver

(a) RESIDENCE NO. 576 Walnut St. 17-24 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6-8 yrs.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Cool 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) June 22-1859

7 AGE Years 68 Months 9 Days 9 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltore Md

(State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14

Informant (Address) 576 Walnut St.

15

Filed 1928

C. HAMPTON JONES, M.D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1928

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. B. Smith M. D.

(Coroner) 31-1928

(Address) 101-201-E 32334

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mauburn Ave Apr 1 1928

20 UNDERTAKER Dan McCarty

Address 916

Q. we.

32335

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 32335

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Mond. Ave. 14 WARD)2. FULL NAME Daniel Cook(a) RESIDENCE NO. 1413 Mond. Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Polish 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1898AGE Years Months Days If LESS than 1 day, hrs. or min. 30

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook(b) General nature of industry, business, or establishment in which employed (or employer) Public(c) Name of employer Jos. HoffmanBIRTHPLACE (city or town) (State or country) Bath, Me.10 NAME OF FATHER Ed. Cook11 BIRTHPLACE OF FATHER (city or town) (State or country) Me.12 MAIDEN NAME OF MOTHER Ann Grogan13 BIRTHPLACE OF MOTHER (city or town) (State or country) Me.14 Informant (Address) Mamie Cook15 File 1928 G. HAMPSON JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-192817 I HEREBY CERTIFY, That I attended deceased from 3/23/28 to 3/29/28, that I last saw him alive on 3/29/28and that death occurred, on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH\* was as follows:

Chol. TyphoidCONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Fr. pneumonia18 Where was disease contracted if not at place of death? Prague, CzechDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) A. Lee M. D.(Address) 924 Mond. Ave.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

National Cem.4-1-28

UNDERTAKER

ADDRESS 916Daniel CookBe all

## HEALTH DEPARTMENT—CITY OF BALTIMORE

2336

## CERTIFICATE OF DEATH.

90 E 32336

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 W. Baltimore ST. 19-27 WARD)

2. FULL NAME Martha Koepf.

(a) RESIDENCE NO. 1410 W. Baltimore ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Emil Koepf

DATE OF BIRTH (month, day, and year) Oct 23, 1867

AGE 60 Years 5 Months 8 Days If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Albert Lindner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emil Koepf (Address) 1410 W. Baltimore St

15 1928 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 31 1928

17 I HEREBY CERTIFY, That I attended deceased from Mch 29, 1928, to Mch 31, 1928,

that I last saw him alive on Mch 31, 1928, and that death occurred, on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis.

(duration) 3 or 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. B. Baum and Good, M. D.

3/31, 1928 (Address) 626 N. Gilman St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cemetery

20 UNDERTAKER

Charles W. Dill

DATE OF BURIAL

April 2, 1928

ADDRESS 3109 Fredk Ave.

32337

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32337

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Greenway Apartments #402* Ward *12-44*)2-FULL NAME *Margaret E. W. Fenhagen*(a) RESIDENCE NO. *Greenway Apartments #402 St.* Ward 

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Dr. Frank C. Fenhagen*6 DATE OF BIRTH (month, day, and year) *Nov. 16, 1863*7 AGE Years *64* Months *11* Days *13* IF LESS than 1 day—hrs. or—min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Duties*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *MD.*10 NAME OF FATHER *Levester Clark*11 BIRTHPLACE OF FATHER (City or town)  
(State or country) *MD.*12 MAIDEN NAME OF MOTHER *Ann Wilson*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *MD.*14 Informant *Charles C. Fenhagen*  
(Address) *2012-13 St. N.W. Wash. D.C.*15 *1920* C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 29, 1928*17 I HEREBY CERTIFY, That I attended deceased from *Nov 26, 1927*, to *March 29, 1928*, that I last saw her alive on *March 29, 1928*, and that death occurred, on the date stated above, at *9:45 P.M.*The CAUSE OF DEATH\* was as follows:  
*Angina Pectoris*

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary) *Arterio Sclerosis**Myocarditis* (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? *✓*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *E. B. Fenhagen**30. 1928* (Address) *1733 Linden St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

*Green Mount Cem., April 2, 1928*  
*John O. Mitchell & Sons 1996 Baltimore, Md.*



32338

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

ST., 7-9 WARD)

### 2-FULL NAME

Mildred Willey  
Norfolk, Va

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs 1 mos

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

DATE OF BIRTH (month, day, and year)

Feb 16 1923

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

1

14

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Norfolk Va.

10 NAME OF FATHER

Carl M. Willey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Norfolk Va.

12 MAIDEN NAME OF MOTHER

Bessie Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Norfolk Va.

Informant (Address)

Mr. Carl M. Willey

15-1928

Filed

C. HAMPSON JONES

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 31, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 30, 1928, to Mar 31, 1928,

that I last saw her alive on Mar 31, 1928,

and that death occurred, on the date stated above, at 11:20 p.m.

The CAUSE OF DEATH\* was as follows:

Brain Tumor - Hypophyseal Duct Tumor - Benign

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

At home

Did an operation precede death? Yes Date of Mar 31, 1928

Was there an autopsy? No

What test confirmed diagnosis?

Operation

(Signed) F. S. Coman, M. D.

, 19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL Enfield, N. C.

April 1, 1928

20 UNDERTAKER

John C. Mitchell Sons 1900 E. Calver St.

2339

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

JOHNS HOPKINS HOSPITAL

ST. 28-63 WARD

### 2-FULL NAME

William Walsh

### (a) RESIDENCE NO.

St. Vincent & Thomas Home

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

M

4 COLOR OR RACE

B

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Feb 6 - 1927

AGE

Years

Mon

Days

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Not given

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Gertrude Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

Informant (Address)

Reeds

15 - 1928 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 31, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1928, to March 31, 1928, that I last saw him alive on March 31, 1928, and that death occurred, on the date stated above, at 8<sup>30</sup> a m.

The CAUSE OF DEATH\* was as follows:

Pertussis

(duration)

yrs.

6 weeks

ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

both lungs (duration)

yrs.

1 mos.

ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

None

(Signed)

J. J. Bennett

M. D.

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Redeemer

DATE OF BURIAL

Apr. 1, 1928

20 UNDERTAKER

Martin J. Jones & Sons 1827 N. North Ave.

32340

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32340

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE

(No. 35 N Catherine ST. 70-69

WARD)

## 2-FULL NAME

James E. Bacon

(a) RESIDENCE NO.

35 N Catherine ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

Single Married, Widowed,  
or Divorced. (write the word)

Male

White

Widowed

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Lydia C. Bacon

DATE OF BIRTH (month, day, and year)

Mar 15 1863

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

64

4

14

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Clerk

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

James E. Bacon

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

MD

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)

35 N Catherine St

15

1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 29 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 25, 1928, to Mar. 29, 1928.

that I last saw him alive on Mar. 29, 1928.

and that death occurred, on the date stated above, at 11:10 P. M.

The CAUSE OF DEATH\* was as follows:

Coronary Syncope

(duration) yrs. mos. 1 ds.

CONTRIBUTORY  
(Secondary)

Bronco-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Robert Creech M. D.

(Address) 2502 Columbia Ave N.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
BURYAL

DATE OF BURIAL

Cathedral Cn

4/2/28

UNDERTAKER

ADDRESS

George A. Finley Teller &amp; Lytle

12 5-90  
32341

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32341

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL*)ST. *7-4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Josephine Jackson*(a) RESIDENCE NO. *Sparrows Pt.*

(Usual place of abode)

ST. *Box 426* WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. *2*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Black Married

If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Walter Jackson*

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*27*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Ga.*10 NAME OF FATHER *Wm. Mills*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ga.*12 MAIDEN NAME OF MOTHER *Lizzie Roberts*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ga.*

14

Informant (Address)

*Records -*

15

Bk.

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 30 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 28 1928 to Mar. 30 1928.*that I last saw her alive on *Mar. 30 1928.*and that death occurred, on the date stated above, at *3* m.

The CAUSE OF DEATH\* was as follows:

*Acute lobar Pneumonia Type IV*

(duration)

yrs.

mos. *14*

ds.

CONTRIBUTORY (Secondary)

*Septicemia Type IV*

(duration)

yrs.

mos. *?*

ds.

18 Where was disease contracted

if not at place of death? *at home*Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis? *X-Ray - Blood Culture*(Signed) *Raymond Waring*, M. D.3/31, 1928 (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Ashley Cemetery**Apr 3 1928*

20 UNDERTAKER

ADDRESS

*Mrs. R. G. Elliott**1725 Ashland*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

960-  
E 32342

## CERTIFICATE OF DEATH.

129 E 32342

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.,

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Roland Hanson*(a) RESIDENCE NO. *Leonardtown, Md*

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

21

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Colored**Married*

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Genevieve*

DATE OF BIRTH (month, day, and year)

*2**1886*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*42**7**7*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town; State or country)

*Md*

10 NAME OF FATHER

*Robert Hanson*

11 BIRTHPLACE OF FATHER (city or town; State or country)

*Md*

12 MAIDEN NAME OF MOTHER

*Seely*

13 BIRTHPLACE OF MOTHER (city or town; State or country)

*Md*

Informant (Address)

*Records*

R 1 - 1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar-31 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 10, 1928, to March 31, 1928,*that I last saw him alive on *March 31, 1928,*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Chronic nephritis - uraemia*(duration) *3-4 yrs.* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Acidosis*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes.*What test confirmed diagnosis? *Above*(Signed) *Christopher Johnston* M. D.19 (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Forest Hill Md.*

DATE OF BURIAL

*4/1 1928*

20 UNDERTAKER

*E. B. Barty*

ADDRESS

*Glenview*

E 32343

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32343

1-PLACE OF DEATH *Sydenham Hospital*

REGISTERED NO.

City of BALTIMORE: (No. *11-24*)St. *11-24* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Jacqueline Lutz*(a) RESIDENCE NO. *1216 Bolton*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *♀* 4 Color or Race *W* 5 Single, Married, Widowed, or Divorced, (write the word) *child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 21, 1924*7 AGE Years *3* Months *8* Days *11* IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) *Baltimore, Md*10 NAME OF FATHER *Harvey Lutz*

11 BIRTHPLACE OF FATHER (City or town)

(State or country) *Baltimore, Md*12 MAIDEN NAME OF MOTHER *Mary O'Connell*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Baltimore, Md*14 Informant *Sydenham Hosp. Records*  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 1, 1928*17 I HEREBY CERTIFY, That I attended deceased from *March 31, 1928*, to *April 1, 1928*.that I last saw her alive on *April 1, 1928*.and that death occurred, on the date stated above, at *12.50 A.M.*

The CAUSE OF DEATH\* was as follows:

*Laryngeal Diphtheria*(duration) *?* yrs. mos. ds.CONTRIBUTORY *Acute Myocarditis*  
(Secondary)(duration) *?* yrs. mos. ds.

18 Where was disease contracted

If not at place of death? -

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? - *Culture*(Signed) *S. Bachman* M. D., 19 (Address) *Sydenham Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Northtown**4/2 1928*20 UNDERTAKER *W. H. Cook*

ADDRESS

*507 E. North Ave*

APR 2 - 1928

REGISTERED

32344

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32344

### 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 3425 Mondawmin Ave. ST. 54 WARD)

### 2. FULL NAME

Dr. Gustav H. Grapp

(a) RESIDENCE NO. 3425 Mondawmin Ave. ST. 54 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 6, 1866

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

10

25

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Veterinarian

(b) General nature of industry, business, or establishment in which employed (or employer)

Self

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Elida H. Grapp 3425 Mondawmin Ave. ST. 54 WARD

2-1928

G. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1928

17

I HEREBY CERTIFY, That I attended deceased from May 1926, to March 31 1928.

that I last saw him alive on March 30 1928.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis (Chronic) Hypertension

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds. Aortic Dilatation

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings (Signed) George R. Wrasing M. D.

, 19 (Address) 4000 Edmondson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

Stearns Grove Cemetery

20 UNDERTAKER

William Cook

DATE OF BURIAL

4/3 1928

ADDRESS

502 E North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32345

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. BALTIMORE CITY HOSPITAL ST., 8-17 WARD)2-FULL NAME See 3 on shell(a) RESIDENCE NO. 1403 W. Bond ST., 8-17 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male4 COLOR OR RACE white5 Single, Married, Widowed, or Divorced, (write the word) married6 If married, widowed, or divorced HUSBAND of or WIFE of Myrtle F. FoshellDATE OF BIRTH (month, day, and year) Dec 30, 1869

AGE

Years 58Months 3Days 1

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer National Surety CoBIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Paul W. Foshell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Connecticut12 MAIDEN NAME OF MOTHER Emma Boyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) MarylandInformant (Address) C. HAMILTON JONES, M. D.Filed 2-1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/1928

17

I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1928, to Mar. 31, 1928that I last saw him live on Mar. 31, 1928and that death occurred, on the date stated above, at 6:40 P. M.

The CAUSE OF DEATH\* was as follows:

myocarditis chronic + acute  
arteriosclerosis  
hypertension(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General + Sub.(Signed) C. Hamilton Jones M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London ParkDATE OF BURIAL 4-1-192820 UNDERTAKER J. M. CookADDRESS 582 E. North Ave



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32346

CERTIFICATE OF DEATH.

101-001 E 32346

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Gilman

ST. 19-27 WARD)

2-FULL NAME

Victoria Smith

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

(Usual place of abode)

504 Gilman

ST. WARD

Length of residence in city or town where death occurred

yrs. 5 mos. 2 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

08-27-27

AGE

Years

Months

Days

If LESS than 1 day, hrs or min

5

2

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Evangelina Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

Informant (Address)

Evangelina Smith 504 N. Gilman

Filed

10

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/31 1928

17

I HEREBY CERTIFY, That I attended deceased from

3/30, 1928, to 3/31, 1928.

that I last saw him live on 3/31, 1928.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Sober pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ben Chitts, M. D.

1928 (Address) 4134 D. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR RE-

MOVAL

DATE OF BURIAL

Apr 21 1928

UNDERTAKER

ADDRESS

Smith, Grace E. 4024 St.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32347

## CERTIFICATE OF DEATH.

86 E 32347

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112.71 Barry

16-23 WARD)

### 2-FULL NAME

Thomas Stovall

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs.

ST.

WARD

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

M

#### 4 COLOR OR RACE

Col

#### 5 Single, Married, Widowed, or Divorced, (write the word)

Married

#### 5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Lilwen Stovall

#### 6 DATE OF BIRTH (month, day, and year)

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 9 BIRTHPLACE (city or town) (State or country)

Manchester

### 10 NAME OF FATHER

Jeff Stovall

### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

### 12 MAIDEN NAME OF MOTHER

Nancy Taylor

### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa

### 14

Informant (Address)

Edice Dorsey 1110 Sarah Ave

2-1928 G. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

March 31 1928

#### 17

I HEREBY CERTIFY, That I attended deceased from Mar 29 1928 to March 31 1928

that I last saw him alive on March 30 1928

and that death occurred, on the date stated above, at 8 PM

The CAUSE OF DEATH\* was as follows:

Trauma of Brain

(duration) yrs. mos. 3 ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

### 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

B. H. Falek

M. D.

(Address) 1228 P St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Hubert

Apr 3 1928

### 20 UNDERTAKER

ADDRESS

Wm. H. Chase

1400 M St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32348

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3660 Sycamore St. 13-57 Ward)2-FULL NAME Thomas Butterfield(a) RESIDENCE NO. 3660 Sycamore St. 13 Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14

Informant  
(Address)

15 Filed

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REGISTERED NO. E 32348

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquest  
(Inquest, autopsy or inquiry)  
thereon and from the evidence obtained by said inquest  
(Inquest, au-  
topsy or inquiry.)  
And that said deceased came to this death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Gas. Poisoning  
(Suicide)

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) J. H. Horman M. D.(Address) 3/30, 1928 32 Roland St.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Parkwood Cem April 2 1928

20 UNDERTAKER

ADDRESS

Chenowethson 3615 Chestnut

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32349

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 W. Lafayette ST. 10-27 WARD)

## 2-FULL NAME

Thomas W. DeLorse

(a) RESIDENCE NO. 1823 W. Lafayette ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 55 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Laura S. Wicker

DATE OF BIRTH (month, day, and year)

Mar 2/54

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

10

28

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Collector Credit Dept

(b) General nature of industry, business, or establishment in which employed (or employer)

with Anna DeLorse

(c) Name of employer

Baltimore Evening News

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Barney DeLorse

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Fannie North

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Mrs Frank D. DeLorse 1823 W. Lafayette St.

PR 2 - 1928

Filed

HARRISON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 30 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 22/28, 1928, to Mar 30, 1928,

that I last saw him alive on Mar 30, 1928,

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis

(duration)

3 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Corna (menie)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

renal tests

(Signed)

H. E. Knipp

M. D.

(Address)

4025 Edmondson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Pk Cemetery

UNDERTAKER

J. J. DeLorse

DATE OF BURIAL

Apr 2 1928

ADDRESS

h. J. DeLorse



## HEALTH DEPARTMENT - CITY OF BALTIMORE

E 32350

## CERTIFICATE OF DEATH

E 32350

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 116 S. Maderia St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman P. Tribull(a) RESIDENCE NO. 116 S. Maderia St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20, 19277 AGE Years 9 Months 11 Days 6 IF LESS than 1 day... hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)10 NAME OF FATHER Herman P. Tribull11 BIRTHPLACE OF FATHER (City or town) Balto. Md. (State or country)12 MAIDEN NAME OF MOTHER Elij. Prasele13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)14 Informant Herman P. Tribull (Address) 116 S. Maderia St.15 Filed 2-19-28 C. H. HANSEN, M. D., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 192817 I HEREBY CERTIFY, That I attended deceased from March 27, 1928, to March 30, 1928, that I last saw him alive on March 30, 1928.and that death occurred, on the date stated above, at 11:40 a. m.

The CAUSE OF DEATH\* was as follows:

DiphtheriaCONTRIBUTORY (duration) yrs. mos. ds. Minutes (Secondary)18 Where was disease contracted 116 S. Maderia St. (duration) yrs. mos. ds. If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Exam(Signed) W. E. McLaughlin M. D.(Address) 3508 Bank St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial April 2, 192820 UNDERTAKER Lilly & Zien Inc. ADDRESS 400 S. Orange St.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

90 E 32351

CITY OF BALTIMORE: (No.)

JONES HOPKINS HOSPITAL

2-FULL NAME *William Reber*

ST. *6-9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *222 N. Castle*

(Usual place of abode)

Length of residence in city or town where death occurred *37* yrs. mos.

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male*

*White*

*Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *3/2/1877*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*57*

*—*

*27*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Barber*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Germany*

10 NAME OF FATHER

*Tony Reber*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Regina Water*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Records*

R-2-1920

REGISTERED

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar-30 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar-21 1928* to *March 30 1928*, that I last saw him alive on *March 30 1928*, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Coronary Sclerosis, Myocardial Infarction*

(duration) yrs. 1 mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *at home*

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Christopher Johnston* M. D.

*3/31 1928 Johns Hopkins Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Open Lawn Cemetery John Cecic*

DATE OF BURIAL

*Apr 2 1928*

ADDRESS

*2008 Orleans St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32352

## CERTIFICATE OF DEATH.

E 32352

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1543 Glenwood Ave ST. 13-57 WARD 90)2-FULL NAME William B. Tase(a) RESIDENCE NO. 1543 Glenwood Ave ST. 13-57 WARD 90

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 8 mos. 5 ds.How long in U. S., if of foreign birth? 2 yrs. 8 mos. 5 ds.

(If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) SingleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of ✓DATE OF BIRTH (month, day, and year) July 26-1907

AGE

Years 20Months 8Days 5If LESS than  
1 day, hrs. 11  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. City10 NAME OF FATHER John W. Tase11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City12 MAIDEN NAME OF MOTHER Robert C. Bosley13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14

Informant (Address) John B. Tase  
1543 Glenwood Ave

15

Filed 1820, 19 20C. HAMMOND JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/1928

17

I HEREBY CERTIFY That I attended deceased from Mar. 3, 1927, to Mar 31, 1928that I last saw him alive on Mar 30, 1928and that death occurred, on the date stated above, at 10:11 PM

The CAUSE OF DEATH\* was as follows:

Acute Myocardial Infarction(duration) 1 yrs. 1 mos. 1 ds.CONTRIBUTORY (Secondary) Myocardial(duration) 4 yrs. 4 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Phys. exam.(Signed) C. F. Chapman, M.D.3/31/28 (Address) 3201 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE St Marys HampdenDATE OF BURIAL Apr 3, 192820 UNDERTAKER AS MarshallADDRESS 3539 Fall Rd





## HEALTH DEPARTMENT—CITY OF BALTIMORE

32354

## CERTIFICATE OF DEATH.

99E 32354  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 316 N. Vincent St. 19-27 Ward 11)2-FULL NAME John Diggs(a) RESIDENCE NO. 316 N. Vincent St. 19-27 Ward 11

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)  
Mar.Male Col.6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Married6 DATE OF BIRTH (month, day, and year)  
evening

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.5-5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work element worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

10 NAME OF FATHER John Diggs11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Md.12 MAIDEN NAME OF MOTHER Don't know13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Md.

14

Informant  
(Address) John Diggs  
316 N. VincentFiled 19281928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29/28

17

I HEREBY CERTIFY, That I attended deceased from  
March 11, 1928, to March 29, 1928,  
that I last saw him alive on March 29, 1928,  
and that death occurred, on the date stated above, at 9:00 p.m.

The CAUSE OF DEATH\* was as follows:

Organic Disease  
of Heart  
(duration) 4 yrs. 4 mos. 4 ds.CONTRIBUTORY  
(Secondary) Pulm. Disease(duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted

If not at place of death? NoDid an operation precede death? NoDate of NoWas there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Woodward

, 19

(Address) 937 W. Fayette

, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt Auburn Cem

UNDERTAKER

A. Jones

ADDRESS

April 2nd 1928  
118 S. Giddens  
St

32355

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

E 32355

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *15163*)St. *Maryland General Hospital* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *3912**Fennhill* St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 Color or Race

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*9-5-06*

7 AGE

Years

Months

Day

IF LESS than 1 day hrs. or min.

*21**6**26*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *Baltimore Md.*10 NAME OF FATHER *Archibald Morrow*

11 BIRTHPLACE OF FATHER (City or town)

(State or country) *Md.*12 MAIDEN NAME OF MOTHER *Ellen Morgan*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Md.*

14

Informant (Address)

*Hosp. Records*

15 Filed

19

*2-19-28*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*3-31-28*

17

I HEREBY CERTIFY, That I attended deceased from

*3-23-28*, 19, to *3-31-28*, 19that I last saw him alive on *3-31-28*, 19and that death occurred, on the date stated above, at *12:50 P. m.*

The CAUSE OF DEATH\* was as follows:

*Gargreous Appendicitis*

CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

*9*

ds.

(duration)

yrs.

mos.

*5*

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *3-23-28*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*

(Signed)

19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Lorraine**Apr 3 1928*

ADDRESS

20 UNDERTAKER

*Mrs. John W. Trefel* Box 501 N. Fayette

E 32356

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3917 Liberty Heights Ave

2-FULL NAME Anna Morgenthall

(a) RESIDENCE NO. 3917 Liberty Heights Ave

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. 49 E 32356

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

15

Filed

2-1928

HAYMON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Mar 30, 1928.

That I last saw her alive on Mar 29, 1928, and that death occurred, on the date stated above, at 5:15 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmos ac Cardiac dilatation sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration)

1 yrs.

2 mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

X-Ray

(Signed)

Martin J. Sloan, M. D.

331, 1928 (Address) 812 Med. Arts Bldg.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park, Apr. 2, 1928. Mrs. John W. Teyfel &amp; Son 11 N. Fayette St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32357

## CERTIFICATE OF DEATH.

90 E 32357  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2-4 ST. 2-4 WARD)2-FULL NAME Mary Casper(a) RESIDENCE No. 616 S. Ann  
(Usual place of abode)ST. 2-4 WARDLength of residence in city or town where death occurred ? yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) WidowIf married, widowed, or divorced  
HUSBAND of Henry Casper  
(or) WIFE ofDATE OF BIRTH (month, day, and year) Feb. 6-1864AGE Years 64 Months 1 Days 25 If LESS than 1 day, 0 hrs. or 0 min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Germany  
(State or country)10 NAME OF FATHER ? don't know11 BIRTHPLACE OF FATHER (city or town) ? don't know  
(State or country)12 MAIDEN NAME OF MOTHER ? don't know13 BIRTHPLACE OF MOTHER (city or town) ? don't know  
(State or country)4 Informant Reverend  
(Address)5 Filed 2-1928

HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 17, 1927, to Mar. 31, 1928that I last saw her live on Mar. 31, 1928.and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. 4 mos. 4 ds.CONTRIBUTORY Chenille  
(Secondary) Myocarditis(duration) ? yrs. 0 mos. 0 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General + Sub(Signed) C. Holmes Stange, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Public Nat. Cem. of Holy Cross

UNDERTAKER

George W. Zirkler

DATE OF BURIAL

4/3 19 28

ADDRESS

1737 E. Eager St



# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32358

31 E 32358  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals ST. 10-14 WARD)

2-FULL NAME James Richardson

(a) RESIDENCE NO. 709 Stirling st.  
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos.

ST. 10-14 WARD

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Separated

If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Richardson

DATE OF BIRTH (month, day, and year) 1874

AGE Years Months Days If LESS than 1 day, hrs. or min. 54

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Frank Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Georgie Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records

15 Filed 2-19-28 JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 19 28

17 I HEREBY CERTIFY, That I attended deceased from March 26, 19 28, to March 29, 19 28, that I last saw him alive on March 29, 19 28, and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) [Signature] M. D.

3-29-28 (Address) Baltimore City Hospitals.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt Calvary Cem.

DATE OF BURIAL

4/2 19 28  
ADDRESS

20 UNDERTAKER

Byron Wright 1218 McAdams St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32359

## CERTIFICATE OF DEATH.

40 E 32359

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hosp* 22-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs Persie E. Walton*(a) RESIDENCE NO. *106-08 W. Conway St.*

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred *20* yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**white**Widowed*(a) If married, widowed, or divorced HUSBAND of (or) WIFE of *Benj Walton*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*42*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Hotel Keeper*

9 BIRTHPLACE (city or town) (State or country)

*Va.*10 NAME OF FATHER *Lewis Riddle*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Va.*12 MAIDEN NAME OF MOTHER *Elizabeth McDonald*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Va.*

14

Informant (Address)

*Gilbert O Riddle 203 Scott St*

15

Filed

1928

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-30-28* 1917 I HEREBY CERTIFY, That I attended deceased from *3-27-28*, 19, to *3-30-28*, 19.That I last saw her alive on *3-30-28*, 19.and that death occurred, on the date stated above, at *1:30 p. m.*

The CAUSE OF DEATH\* was as follows:

*Generalized Peritonitis Secondary to follicular peritonitis - from ruptured tube.*CONTRIBUTORY (Secondary) *Tubercular Pneumonia* (duration) yrs. mos. *10* ds.(duration) yrs. mos. *1* ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Clinical*(Signed) *Seal M. Hall* M. D.19 (Address) *Franklin Sq. Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Woodlawn Cemetery**April 2, 1928*

20 UNDERTAKER

ADDRESS

*W. M. Routson**22387 m m ch*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32360

## CERTIFICATE OF DEATH.

31 E 32360

## 1. PLACE OF DEATH

CITY OF BALTIMORE

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

C.

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

DATE OF BIRTH (month, day, and year)

Aug. 4, 1916

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

11

7

27

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Augustus Ga.

10 NAME OF FATHER

James Braun

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Augustus Ga.

12 MAIDEN NAME OF MOTHER

Julia Simpkins

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ga.

Informant  
(Address)Julia Braun Mother  
Washington D. C.R 7-1928  
FiledC. HAMPTON JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 31 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Jan. 30, 1928, to Mar. 31, 1928,  
that I last saw her alive on Mar 31, 1928,  
and that death occurred, on the date stated above, at 9.5 p.m.  
The CAUSE OF DEATH\* was as follows:

Tuberculous Pneumonia

(duration) yrs. 2 mos ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual means  
(Signed) Mary F. Voeglin M. D.

(Address) 3.36.1928 1028 Valley St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Washington D. C.

Apr 3, 1928

UNDERTAKER

ADDRESS

The A. G. Elliott

1127 Ashland Ave.

# E 32361 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 N. Biddle ST. 11-24 WARD)

### 2. FULL NAME

(a) RESIDENCE NO. 337 N. Biddle ST., WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX F 4 COLOR OR RACE C. 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced  
HUSBAND of Rensie Wofford  
or WIFE of

DATE OF BIRTH (month, day, and year) April 1st 1883  
AGE Years 45 Months Days If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook or

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Bk.  
(State or country)

10 NAME OF FATHER James Custer

11 BIRTHPLACE OF FATHER (city or town) Bk.  
(State or country)

12 MAIDEN NAME OF MOTHER Maggie Henry

13 BIRTHPLACE OF MOTHER (city or town) Bk.  
(State or country)

4 Informant Amiey Premier  
(Address) 2422

5 R 2 - 1928 HAYES, M. D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1st 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar 31st 1928, to Apr 1st 1928, that I last saw him alive on Apr 1st 1928, and that death occurred, on the date stated above, at 1:45 m. The CAUSE OF DEATH\* was as follows:

Cancer of Uterus and appendices  
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion  
(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No  
(Signed) D. Grant Scott, M. D.

, 19 (Address) 334 N. Biddle St.  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mr. R. G. Elliott  
1125  
Washington





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32363

## CERTIFICATE OF DEATH.

E 32363

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *400 Potomac Ave* *25-75* *WARD*)2. FULL NAME *Jannie Lane Pillsbury*(a) RESIDENCE NO. *400 Potomac Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *58* yrs. — mos. *19* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident, give city or town and State)

How long in U. S., if of foreign birth? *Life* mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *♀* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of *Richard H. Pillsbury*6 DATE OF BIRTH (month, day, and year) *May 12 - 1840*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min. *88* — *19*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Home*(b) General nature of industry, business, or establishment in which employed (or employer) *Home*

(c) Name of employer

9 BIRTHPLACE (city or town) *Westmoreland Co., Va*  
(State or country)10 NAME OF FATHER *Jeremiah Courtney*11 BIRTHPLACE OF FATHER (city or town) *Va*  
(State or country)12 MAIDEN NAME OF MOTHER *Lidia Ann Courtney*13 BIRTHPLACE OF MOTHER (city or town) *Va*  
(State or country)

14

Informant *Daughter Mrs Morris*  
(Address) *same*

15

Filed

R 2 - 1928

H. HANFORD JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 31 - 1928*

17

HEREBY CERTIFY, That I attended deceased from *May 25th* 1928 to *May 31st* 1928.that I last saw him alive on *May 31st* 1928.and that death occurred, on the date stated above, at *150 P* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*CONTRIBUTORY (Secondary) *Multiple neuritis with shock*  
(duration) yrs. mos. ds. *10*  
(duration) yrs. mos. ds. *10*18 Where was disease contracted *same*  
if not at place of death?Did an operation precede death? *No* Date of *✓*Was there an autopsy? *No*What test confirmed diagnosis? *Examination*(Signed) *Robert H. Johnson, M. D.*19 (Address) *Brooklyn, Md.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*London Park*

DATE OF BURIAL

*Official 3-28*

20 UNDERTAKER

*John F. Denny*

ADDRESS

*715 Light St*

32364

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32364

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1600 Rosedale 16-67 Ward)

Registered No. ....

2-FULL NAME Catherine Williams Cropper

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1600 Rosedale St. .... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. .... mos. .... ds. How long in U. S. if of foreign birth? yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-Single, Married, Married, Widowed, or Divorced, (Write the word.)5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Cropper6-DATE OF BIRTH (month, day and year) June 20/18887-AGE, 69 yrs. 9 mos. 11 ds. If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Home wife  
(b) General nature of industry, business, or establishment in which employed (or employer) ...  
(c) Name of employer.....9-BIRTHPLACE (city or town), Dorchester Co (State or Country), Ma10-NAME OF FATHER, John Warfield11-BIRTHPLACE OF FATHER (city or town), Ma (State or Country),12-MAIDEN NAME OF MOTHER, Margaret J. Thomas13-BIRTHPLACE OF MOTHER (city or town), Ma (State or Country),11- (Informant) Mrs. John R. Higgins (Address) 1600 Rosedale St15- PR 2-1928 HAMPSON JONES, M.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-31-2817- I HEREBY CERTIFY, That I attended deceased from July, 1926, to March 31, 28, that I last saw him alive on March 31, 1928, and that death occurred, on the date stated above, at 12:00 M.

The CAUSE OF DEATH\* was as follows:

Carcinoma, Duodenum, Secondary, Kidney's, Liver.CONTRIBUTORY (Secondary) Raymer & Schuck (Duration) 2 yrs. .... mos. .... ds.

18-Where was disease contracted If not at place of death? .....

Did an operation precede death? no Date of .....Was there an autopsy? noWhat test confirmed diagnosis? Chemical(Signed) H. C. Allen M. D.3/31/28 (Address) 2707 W. Norton

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Olivet DATE OF BURIAL, Apr 3, 192820-UNDERTAKER, John R. Denny ADDRESS 715 Light St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32365

## CERTIFICATE OF DEATH

38 ✓  
E 32365  
REGISTERED NO.

1-PLACE OF DEATH

Colonial Hospital

City of BALTIMORE: (No. 1122 N. Mount St. 13-59 Ward)

2-FULL NAME

Elzie Franklin

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2415 Ething

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

December 1st 1910

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

18

yrs

5

30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

Porter

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

The Buchanan 2415 Ething St.

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 31

19

28

17

I HEREBY CERTIFY, That I attended deceased from

March 29, 1928, to March 31, 1928.

that I last saw him alive on March 31, 1928.

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH\* was as follows:

Convulsions of unknown character

(duration) yrs. mos. 46 hrs

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Bialostocky, M. D.

. 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

May Gross Inc 4/3 1928  
Gement Hensley M. B. B.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32366  
PLACE OF DEATH179 E 32366  
REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St. 18-26 Ward)

2-FULL NAME Gladys Evans

(a) RESIDENCE NO. 752 Vine St

(Usual place of abode)

Length of residence in city or town where death occurred

St. Ward

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

female col

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 12/27

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

1

0

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

none

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER

Thos. Evans

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Annie Evans

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant Annie Evans

(Address)

752 Vine St

15

Filed..... 19

C. HAMMOND JONES

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 31/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Burns-Fell in tub of hot water in home.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) J. H. Jones M. D.

(Coroner)

(Address)

3/2/28

508 E. North Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32367

## CERTIFICATE OF DEATH.

E 32367  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 506 W. Hoffman Ward 7-24)2-FULL NAME Wm F. Greenwood(a) RESIDENCE NO. 506 W. Hoffman Ward 7-24

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 Color or Race white5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth H. Greenwood6 DATE OF BIRTH (month, day, and year) 1833

## 7 AGE

Years 73

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Porter(b) General nature of industry, business, or establishment in which employed (or employer) RR

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

10 NAME OF FATHER John H. Greenwood11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

PARENTS

14

Informant (Address) Elizabeth Greenwood  
506 W. Hoffman15 Filed 1928

12

JAMES M. JONES, M.D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29<sup>th</sup> 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach  
(duration) 3 yrs. - mos. - ds.

## CONTRIBUTORY (Secondary)

F.B. Lusk M. D.  
(Signature) Mar 29<sup>th</sup> 1928 (Address) North Art Union

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial

Cemetery 4/7/28

20 UNDERTAKER

ADDRESS

Anna H. Newley 1128

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32368

## CERTIFICATE OF DEATH.

38 E 32368

1-PLACE OF DEATH *Balto City Hosp*CITY OF BALTIMORE: (No. *Balto Md* ST. *23-31* WARD)2-FULL NAME *Mary E. Johnson*(a) RESIDENCE NO. *1103 S. Sharp St* ST. *38* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Female*

4 COLOR OR RACE

*Black*5 Single, Married, Widowed,  
or Divorced, (write the word)*Widow*If married, widowed, or divorced  
HUSBAND of  
or) WIFE ofDATE OF BIRTH (month, day, and year) *1859*

AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

*Housework*BIRTHPLACE (city or town)  
(State or country)*Maryland*

10 NAME OF FATHER

*Unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Unknown*Informant  
(Address)*Balto City Hosp*15  
Filed

19

*C. H. JONES, M.D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-30-1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*2-23-1928* to *3-30-1928*  
that I last saw him alive on *3-30-1928*and that death occurred, on the date stated above, at *11:05 P.* m.

The CAUSE OF DEATH\* was as follows:

*General Paralysis of Insane*

(duration) yrs. mos. ds.

CONTRIBUTORY *Psychosis of Cerebro Spinal Axis*

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*Harry J. Jones, M.D.*

(Address)

\*State the Disease Causing Death, or in death from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St. Auburn Cem**4/3/28*

FUNERAL

ADDRESS

*James H. Hensley*

HEALTH DEPARTMENT—CITY OF BALTIMORE **E 32369****32369**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. **1601 E. 28th Street** ST. **WARD**)2-FULL NAME **JOHN W. SEEGRUBER**(a) RESIDENCE No. **1601 E. 28th Street**

(Usual place of abode)

Length of residence in city or town where death occurred **Life**

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

**Male****White****Married**

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

**Kate Seegruber**DATE OF BIRTH (month, day, and year) **December 9, 1860**

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.**67****3****21**

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **Barber**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)**Baltimore**10 NAME OF FATHER **Martin Seegruber**

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

**Germany**12 MAIDEN NAME OF MOTHER **Margaret Gehring**

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

**Germany**

14

Informant **Mrs. Kate Seegruber (Wife)**

(Address)

**1601 E. 28th St.**

15

Filed

**1928****C. HARRISON JONES, M. D.**

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **March 30 1928**

17

I HEREBY CERTIFY, That I attended deceased from

**March 30th, 1928, to March 30th, 1928,**that I last saw ~~him~~ alive on " " " " 1928and that death occurred, on the date stated above, at **10.45 a. m.**

The CAUSE OF DEATH\* was as follows:

**Apoplexy**(duration) yrs. mos. **1** ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? **no** Date ofWas there an autopsy? **no**

What test confirmed diagnosis?

(Signed) **Jacob L. Warner**, M. D.**3-30, 1928** (Address) **308 B'way**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

**Druid Ridge Cemetery.****April 2 1928**

20 UNDERTAKER

**Henry Sander & Sons Inc**ADDRESS  
**BALTIMORE ST  
& BROADWAY**



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32370

## CERTIFICATE OF DEATH.

E 32370

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin St. 46728*)

## 2-FULL NAME

(a) RESIDENCE NO. *1933 N. Lombard St.*

(Usual place of abode)

Length of residence in city or town where death occurred *14 yrs. 4 mos.*

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Ind white Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 Filed

JANESON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
*Ruptured Spleen  
Internal injury chest  
Struck by auto*CONTRIBUTORS  
(Second)(Signed) *Thos. B. Horton* M. D.(Address) *Curtis Bay*

State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal (See instructions for address on back.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

*George L. Schwal. 1201 E. 1st Ave.*

32371

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32371

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO.

BALTIMORE CITY HOSPITAL

ST. WARD

2. FULL NAME

Charles Owens

(a) RESIDENCE NO.

615 S. Vermont ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

2

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

Caucasian

Widowed

If married, widowed, or divorced  
HUSBAND of  
or WIFE of

?

DATE OF BIRTH (month, day, and year)

?

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

49

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sculptor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

?

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

?

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

?

Informant  
(Address)

C. HARRISON JONES, M.D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29/ 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 29, 1928, to Mar. 29, 1928.

that I last saw him live on Mar. 29, 1928.

and that death occurred, on the date stated above, at 1:00 P. M.

The CAUSE OF DEATH\* was as follows:

Sudden pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted?  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General &amp; Spleen

(Signed) C. Harrison Jones, M.D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

PLACE OF BURIAL

UNDERTAKER

ADDRESS

1928

19

C. HARRISON JONES, M.D.

Reg.

Registrar

Commissioner of Health

Walter P. Huggins

APR 2

1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32372

## CERTIFICATE OF DEATH.

91-003  
E 32372

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor 10-14 Ward)2-FULL NAME George M. McCreary(a) RESIDENCE NO. Preston + Valley St. \_\_\_\_\_ Ward \_\_\_\_\_(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year) Dec 28<sup>th</sup> 18447 AGE 83 Years 3 Months 3 Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Baltimore  
(State or country) \_\_\_\_\_10 NAME OF FATHER Arthur M. McCreary11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_12 MAIDEN NAME OF MOTHER Emily Wolf13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_14 Informant Little Sisters of the Poor  
(Address) Preston + Valley St15 Filed 2-19-28 19 Feb 19 1928 M. D. Registrar R. M. C.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31<sup>st</sup> 192817 I HEREBY CERTIFY, That I attended deceased from 3/29, 1928, to 3/31, 1928, that I last saw him alive on 3/31, 1928, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH\* was as follows:

Senile arteriosclerosis  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY (Secondary) \_\_\_\_\_  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.18 Where was disease contracted  
If not at place of death \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) D. Demas Wills, M. D.  
(Address) 914 E. Biddle

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial Apr 2 192820 UNDERTAKER Rita Wiedefeld ADDRESS 914 Greenbelt Ave

32373 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Madison Ave. ST. 14-20 WARD)

2. FULL NAME Addie H. Hampton

(a) RESIDENCE NO. 1714 Madison Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 15, 1883

AGE Years 45 Months 1 Days 14 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Howard Co (State or country) Md

10 NAME OF FATHER Wm. Hampton

11 BIRTHPLACE OF FATHER (city or town) Howard Co (State or country) Md

12 MAIDEN NAME OF MOTHER Augusta Bonds

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country) Md

14 Informant Lavinia Hampton (Address) 1714 Madison Ave

15 Registrar C. HAMPTON JONES, M.D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1928

17 I HEREBY CERTIFY, That I attended deceased from 4/4/1928 to March 28, 1928, that I last saw her alive on 3/28, 1928, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH\* was as follows:

Eczema of Cervix Uteri

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) A. Lee Blair, M.D.

3/30, 1928 (Address) 924 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Auburn Cemetery

4/2 1928

20 UNDERTAKER

ADDRESS

Thomas G. Kelan

1303

Preston St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32374

1-PLACE OF DEATH

City of BALTIMORE: (No. 672 W. Baltimore St. 4-25 Ward)2-FULL NAME William Y. Skleres(a) RESIDENCE NO. 672 W. Balto

(Usual place of abode)

St. 4-25 Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 12 - 1928

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

6

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto. Md

10 NAME OF FATHER

John Skleres

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Greece

12 MAIDEN NAME OF MOTHER

Ethel Waugar

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Greece

14

Informant  
(Address)John Skleres  
672 W. Baltimore St

15 Filed

1928

C. H. B. J. M. D.

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.) and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) Agnes J. M. D.  
(Coroner)4-2-1928 (Address) 2739 Eastern av\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVALWoodlawn Cemetery April 21 1928

20 UNDERTAKER

ADDRESS

C. H. B. J. M. D. 103 W. ...

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32375

## CERTIFICATE OF DEATH.

114 E 32375

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Little Sisters of the Poor* 10-14 Ward)

## 2-FULL NAME

*Lewis Koch*

## (a) RESIDENCE NO.

*Preston + Valley*

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *70* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced. (write the word)

*Male White Married*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Louisa Koch*

## 6 DATE OF BIRTH (month, day, and year)

*Oct 31 - 1857*

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.*70**5**1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

*Baltimore*

(State or country)

## 10 NAME OF FATHER

*Lewis Koch*

## 11 BIRTHPLACE OF FATHER (city or town)

*Germany*

(State or country)

## 12 MAIDEN NAME OF MOTHER

*Catherine Koch*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Germany*

(State or country)

## 14

Informant  
(Address)*Little Sisters of the Poor  
Preston + Valley St*

## 15 Filed

19

*W. H. Jones*

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*3/26*, 19*28*, to *3/31*, 19*28*,that I last saw him alive on *3/31*, 19*28*,  
and that death occurred, on the date stated above, at *1* P. m.

The CAUSE OF DEATH\* was as follows:

*Chronic Intermittent Colitis*(duration) ..... yrs. *6* mos. .... ds.

## CONTRIBUTORY

(Secondary)

(duration) ..... yrs. .... mos. .... ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?..... Date of.....

Was there an autopsy?

What test confirmed diagnosis?

Signed) *Dr. Demarest*, M. D.4-2-28 (Address) *914 E. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Oak Lawn**4-4-28*

## 20 UNDERTAKER

ADDRESS

*Mrs Chas G Rohde**3827**Edmondson Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32376

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

Body found in the water at the  
Foot of Jackson St. St. 24-23 Ward)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## 2-FULL NAME

Columbus A. Cannon.

## (a) RESIDENCE NO.

1207 Riverside Ave.

St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred

48 yrs. ————

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male.

## 4 Color or Race

White.

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married.

6a If married, give name of  
HUSBAND OF  
XXXXXXXXXX

Arona D. Cannon.

## 6 DATE OF BIRTH (month, day, and year)

July 1, 1853

## 7 AGE

Years

74

Months

7

Days

30

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Mariner.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Cambridge, Md.

## 10 NAME OF FATHER

Perry Cannon.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Dorchester Co., Md.

## 12 MAIDEN NAME OF MOTHER

Elizabeth Kingett.

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Dorchester Co., Md.

## 14

Informant Edgar L. Cannon, (son)  
(Address) 516 E. Eager St.

## 15

PR 2 - 1928

HARRISON JONES, M.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)  
Missing Feb 10, 1928 body found March 31 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
inquiry find that said deceased came to death  
(Inquest, au-  
topsy or inquiry.)on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Occidental Drowning.  
Occidental fall from a boat.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) [Signature] M. D.  
(Coroner)

8/31/1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Mt. Olivet. Cem 4/2 1928

## 20 UNDERTAKER

J. Hew M. Gully 120 E. Fort

32377

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Superior R. R. Station* St., *14* Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Sarah P. Cooper*(Residence in Baltimore: No. *84 Mt Carmel Way, Ocean Grove, N.J.* St., yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Female*

4-COLOR OR RACE,

*White*5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH,

*March 12, 1852*  
(Month) (Day) (Year)

7-AGE,

*76* yrs. *0* mos. *21*<sup>20</sup> ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- 
- (b) General nature of industry, business, or establishment in which employed (or employer).

*housewife*

9-BIRTHPLACE, (State or Country)

*Pennsylvania*

10-NAME OF FATHER,

*William H. Coopers*

11-BIRTHPLACE OF FATHER, (State or Country)

*Penn.*

12-MAIDEN NAME OF MOTHER,

*Mary Kitchen*

13-BIRTHPLACE OF MOTHER, (State or Country)

*Penn.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Samuel H. Cooper*

(Address)

*Ocean Grove, N.J.*

15-

Filed

1921 MAR 14 JONES, M. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*April 2, 1928*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest* (Inquest, au-topsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Calcular**Renal**Heart*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *John H. Harrison* M. D.

(Coroner.)

1928 (Address) *3632 R. Route 1*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Elizabeth, N.J.**April 2, 1928*

20-UNDEBTAKER,

*E. L. Stuffer*

ADDRESS

*125 E. North Ave*



E 32378

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32378

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1418 Euter Place H A Kelly Hospital  
 CITY OF BALTIMORE: (No. 1418 Euter Place ST. 14-170 WARD) REGISTERED NO. 173  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 2-FULL NAME John Samuel Offutt M.D.  
 (a) RESIDENCE NO. Capon Bridge W. Va. ST. WARD  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. 11 ds. (If non-resident give city or town and State)  
 How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863 Oct 12  
 7 AGE 64 Years Months Days If LESS than 1 day, hrs or min. 20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Capon Bridge W. Va.

10 NAME OF FATHER John T. Offutt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston W. Va.

12 MAIDEN NAME OF MOTHER Sarah Nixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Capon Bridge W. Va.

14 Informant Mrs Anna O. Ward (sister) (Address) Capon Bridge W. Va.

15 Filed 1928 HAMPDEN JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2 1928

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1928, to Apr 2, 1928, that I last saw him alive on Apr 2, 1928, and that death occurred, on the date stated above, at 11:00 a. m.

The CAUSE OF DEATH\* was as follows:

gallstones, causing obstruction and jaundice.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

operation

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? W. Va.

Did an operation precede death? yes Date of Mar 28, 1928

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed)

Edmund Kelly

M. D.

4-2, 1928 (Address) 1418 Euter Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Capon Bridge W. Va. April 2, 1928

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 E. North Ave.

E 32379

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32379

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1112 S. Paca St. 21 Ward)2-FULL NAME Jennie Adame(a) RESIDENCE NO. 1112 S. Paca St. 21 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race White5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F. Adame6 DATE OF BIRTH (month, day, and year) March 1, 1853

7 AGE

Years 75Months 0Days 31IF LESS than 1 day... hrs. or... min.. 30

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Calvert Co. Md10 NAME OF FATHER James Thomas

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvert Co. Md12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

PARENTS

14

Informant Carrie Adame  
(Address) 1112 S. Paca St

15 - 1928 G. HAMPSON JONES, M. D. Registrar

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 192817 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1928 to March 31, 1928that I last saw her alive on March 30, 1928and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac dilatation(duration) yrs. mos. ds. 0CONTRIBUTORY Cardiac hypertrophy  
(Secondary) arterio sclerosis(duration) yrs. mos. ds. 3

18 Where was disease contracted

If not at place of death? —Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis Clinical(Signed) W. B. Freilinger, M.D.4-1-1928 (Address) 682 W. 1st St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western CemeteryDate of Burial April 3, 192820 UNDERTAKER Margaret S. FlynnADDRESS 1400 N. 1st St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32380

## CERTIFICATE OF DEATH.

90 E 32380

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 737 E. Fort Ave.

## 2-FULL NAME

William G. Knight.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 737 E. Fort Ave.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 9 mos. 13 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male.

White.

Married

5a If married, ~~Widowed~~ divorced  
HUSBAND of  
~~XXXX XXXXX~~

Rose Knight.

6 DATE OF BIRTH (month, day, and year)

June 18, 1886

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

41

9

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass bottle packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Jacob Knight.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

## 12 MAIDEN NAME OF MOTHER

Sarah Walton.

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant Rose Knight. (wife)

(Address) 737 E. Fort Ave.

15

C. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency.  
Acute dilatation of the Heart.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed) (Coroner)

3/31/28 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Olivet Cemetery

Date of Burial

4/3/28

## 20 UNDERTAKER

E. J. Fanning, Jr. - 1460 Battery Rd.

E 32381

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32381

1-PLACE OF DEATH Pronounced dead at  
City of BALTIMORE: (No. St. Joseph Hospital St. 9-18 Ward)

2-FULL NAME Frank P. Haughey

(a) RESIDENCE NO. 1605 Aisquith St. St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) wowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Late Mary Haughey  
6 DATE OF BIRTH (month, day, and year) Nov 18, 1860

7 AGE Years 67 Months 4 Days 12 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

## 10 NAME OF FATHER

Arthur B. Haughey

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

## 12 MAIDEN NAME OF MOTHER Rose McEvitt

13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)

## 14

Informant Mrs Mamie Kehl

(Address) 1605 E. 25th St.

## 15

1928 C. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30-28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Chr. Myocarditis

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) J. M. Jones, M. D. (Coroner)

4/2/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Redeemer 11/3/28

20 UNDERTAKER ADDRESS

Gen. J. P. Jones 1735 N. Ave.



E 32382

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001  
E 32382

1-PLACE OF DEATH

St Joseph Hospital

CITY OF BALTIMORE: (No.

Anna Glass

ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna Glass

(a) RESIDENCE NO.

1819 Dallas

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced. (write the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Robert L. Glass

7 DATE OF BIRTH (month, day, and year)

August 11-1895

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

7

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Peter Brosnan

11 BIRTHPLACE OF FATHER (city or town)

Ireland

(State or country)

12 MAIDEN NAME OF MOTHER

Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Robert L. Glass 1819 Dallas

15

1028 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/31/28

17

I HEREBY CERTIFY, That I attended deceased from

3/29/28, 19 to 3/31/28, 19

that I last saw him alive on 3/31/28, 19

and that death occurred, on the date stated above, at 5:18 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman A. Voryl, M. D.

, 19 (Address) St Joseph Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

4/3/28

20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Harford Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32383

## CERTIFICATE OF DEATH

159-003  
E 32383  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 823 Eastern St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gabriel Bunes(a) RESIDENCE NO. 823 Eastern St. 3-5 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day... hrs.  
or... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

March 24, 1928, to April 2, 1928,

that I last saw him alive on April 2, 1928,

and that death occurred, on the date stated above, at 3:30 pm

The CAUSE OF DEATH\* was as follows:

Congenital Atresia of  
Esophagus

(duration) yrs. mos. 9 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert Scagnetti, M. D.

(Address) 244 S. Euter St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32384

## CERTIFICATE OF DEATH.

90 E 32384

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles H. Hawkins

6 DATE OF BIRTH (month, day, and year) June 23, 1862

7 AGE Years 65 Months 9 Days 7 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

## 15

Filed

C. HAMPTON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH\* was as follows:

Coronary Disease of Heart (duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) J. H. Morrison, M. D. (Coroner)

4/1, 1928 (Address) 3632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., ....mos., ....ds. In the State.....yrs., ....mos., ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Oaklawn Cemetery April 3, 1928

## 20 UNDERTAKER

E. Leroy Stiffler 125 E. North Ave.

E 32385

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32385

1-PLACE OF DEATH

City of BALTIMORE: (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Caucasian

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Nellie Williams

6 DATE OF BIRTH (month, day, and year)

Nov 11, 1856

7 AGE

Years

Months

Days

IF LESS than  
1 day \_\_\_\_\_ hrs.  
or min. \_\_\_\_\_

71 4 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer R.P.

(b) General nature of industry, business, or establishment in which employed (or employer)

Mil Industry  
Baltimore Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md

10 NAME OF FATHER

A. C. Williams

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Susan Gorman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

14

Informant  
(Address)

Hospital Record

15 Filed

C. HAMPSON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 1st, 1928

17

I HEREBY CERTIFY, That I attended deceased from

2-18-28, 19 \_\_\_\_\_, to 4-1-28, 19 \_\_\_\_\_

that I last saw him live on

4-1-28, 19 \_\_\_\_\_

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of colon  
acute appendicitis

(duration) 10 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

CONTRIBUTORY

(secondary)

Cerebral Failure  
Carcinoma of Lung

(duration) 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

Yes Date of 3-6-28

Was there an autopsy?

No

What test confirmed diagnosis?

Specimen

(Signed)

, 19 \_\_\_\_\_

(Address)

J. H. Thompson, M. D.  
1105 Guilford

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park Cemetery

April 5, 1928

20 UNDERTAKER

ADDRESS

E. L. Roy Stebbins

125 E. North Ave



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32386

E 32386

## CERTIFICATE OF DEATH.

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3903 Carlisle Ave. 15-65)

### 2. FULL NAME

(a) RESIDENCE NO. 3903 Carlisle Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male White married

If married, widowed or divorced HUSBAND or WIFE of

Laura Theaton Rotapang

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61 10 20

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Traveling Salesman

Agriculture

Supplements

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Laura T. Rotapang 3903 Carlisle Ave.

15

1928

HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1928, to April 1, 1928, that I last saw him alive on April 1, 1928, and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis  
Diabetes mellitus  
Uræmic Toxaemia

(duration) yrs. mos. 5 ds. CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 17 yrs. mos. ds. 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James S. Glendon, M. D.

Address 4012 Park Heights Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDER-TAKER

DATE OF BURIAL

ADDRESS

Goodlaw Cemetery  
The Redman & Sons

April 3, 1928  
North Ave

E 32387

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32387

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5007 Wilson Ave 27-56)

## 2-FULL NAME

Ellen D. Strohmeyer

(a) RESIDENCE NO. 5007 Wilson ST.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 8 mos. 11 ds.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

(a) If married, widowed, or divorced HUSBAND or (or) WIFE of

Jay W. Strohmeyer

DATE OF BIRTH (month, day, and year)

June 18, 1897

AGE

30

Months 8

Days 11

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

James T. Galloway

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Richmond, Va.

12 MAIDEN NAME OF MOTHER

Rose Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Richmond, Va.

14 Informant (Address)

Mr. Jay W. Strohmeyer 5007 Wilson Ave

15

1928

HARRISON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 1, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 22, 1928, to

Apr 1, 1928

that I last saw her alive on

Apr 1, 1928

and that death occurred, on the date stated above, at

9:20 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Leucemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Acute Myocarditis

(duration) yrs. mos. 12 hours ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

M. B. Baumgardner, M.D.

2, 1928 (Address)

626 N. Gilman St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm. J. Dickner 1200 North St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32388

## CERTIFICATE OF DEATH.

90 E 32388

## 1-PLACE OF DEATH

City of BALTIMORE: (No. #15 So. Wickham Road Ward 5-71)

## 2-FULL NAME

(a) RESIDENCE NO. #15 So. Wickham Road Ward 5-71

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male White Married

6a If married, widowed or divorced  
HUSBAND of  
(or) WIFE of

Chas R. Wallace

6 DATE OF BIRTH (month, day, and year)

Apr 12 - 1868

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

39 11 18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Housewife

9 BIRTHPLACE (city or town)

(State or country)

Balto

10 NAME OF FATHER

Francis Carr

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto

12 MAIDEN NAME

Emily Henry

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto

14

Informant

(Address)

Chas. R. Wallace

#15 So. Wickham Road

15

1928

C. HANCOCK JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 - 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held inquest, (Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained inquest, andand that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Patrol Regurgitation  
Found dead in bedCONTRIBUTORY  
(Secondary)(Signed) Thos. B. NortonM. D.  
1928 (Address) Curtis Bay\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (S. Reverse for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

London Park

Date of Burial  
4/3 1928

20 UNDERTAKER

Wm Cook

ADDRESS

502 Chatham Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32389

## CERTIFICATE OF DEATH.

128 E 32389

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

ST. 34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Jones Dennis

(a) RESIDENCE NO. 228 S. Spring

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

married

If married, widowed, or divorced HUSBAND of (or) WIFE of

James Dennis

DATE OF BIRTH (month, day, and year)

May 24-1896

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

31

10

6

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore

10 NAME OF FATHER

James Jones

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

va.

12 MAIDEN NAME OF MOTHER

Bettie Taylor

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

Informant

(Address)

Ellis Brown  
711 N. Caroline St.

Filed

1928

HAROLD JONES, M.D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 31 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

ac Asphyxia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Chastity

(duration) yrs. mos. ds.

(Signed) M. D.

192 (Address) 1436 S. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR REBURYAL

DATE OF BURIAL

19 UNDERTAKER

ADDRESS

Ashbury Cemetery Apr. 4 1928  
Chas. H. Johnson 416 N. Caroline St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32390

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Motherhouse of Notre Dame* ST. *10-14* WARD)2. FULL NAME *Sister Mary Rudolph Schraepfer*(a) RESIDENCE NO. *Disquith St Ashland Ave* WARD(Usual place of abode)  
Length of residence in city or town where death occurred

10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32390

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May - 22 - 1841*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*36**10**10*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Teacher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *New York* (State or country) *N. Y.*10 NAME OF FATHER *Valentine Schraepfer*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Barbara Lutz*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14

Informant *Sister Mary Diomed* (Address) *Notre Dame Disquith St. City*

15

R 3 Filed 1928 HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April - 1 - 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Nov - 20 - 1918* to *April - 1 - 1928*, that I last saw her alive on *April - 1 - 1928*, and that death occurred, on the date stated above, at *7:30 p. m.* The CAUSE OF DEATH\* was as follows:*Myocarditis*  
*Chr Nephritis*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Usual*(Signed) *J. J. Sticks*2, 1928 (Address) *110 E North Ave*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Notch Cliff Rd.*

20 UNDERTAKER

*Frank A. Pink*

ADDRESS

*915 Mt Gay*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32391

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *15-64* St. *15-64* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Boy Basil*(a) RESIDENCE NO. *3711 Liberty Hgts. Ave.* St. *15-64* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*3-31-28*

7 AGE

Years

Months

Days

IF LESS than 1 day 4 hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

14

Informant (Address)

*Hospital Records*

15 Filed

C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*3-31-28*

17

I HEREBY CERTIFY That I attended deceased from

*3/31/28*, 19 *28*, to *3/31/28*, 19that I last saw him alive on *3/31/28*, 19and that death occurred, on the date stated above, at *10:40 P.M.*

The CAUSE OF DEATH\* was as follows:

*Immaturity*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

19

Address

\*State the Disease Causing Death, in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

## 2-FULL NAME

Ossie Jones

## (a) RESIDENCE No.

120 S. Bond

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

male

black

child

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

April 24, 1926

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

23

11

7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Md.

## 10 NAME OF FATHER

Ossie Jones

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Victoria Chappell

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

## 14

Informant

(Address)

Records

JOHNS HOPKINS HOSPITAL

## 15

Filed

1926

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3/31 1928

## 17

I HEREBY CERTIFY, That I attended deceased from 3/23, 1928, to 3/31, 1928,

that I last saw him alive on 3/31, 1928,

and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculous meningitis.

(duration) yrs. mos. 18 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture, Tuberculin.

(Signed) J. T. Bennett, M. D.

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Ashbury

April 2, 1928

## 20 UNDERTAKER

John W. Henderson

ADDRESS 1302 E. Monument

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32393

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 19-27 Ward)2-FULL NAME Beatrice Chase(a) RESIDENCE NO. 501 N. Mount St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred 27 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.E 32393  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

Female

Negro

Married

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Melvin Chase

6 DATE OF BIRTH (month, day, and year)

June 9 - 1900

7 AGE

Years

Months

Days 27 IF LESS than  
1 day \_\_\_\_\_ hrs. \_\_\_\_\_  
or \_\_\_\_\_ min.

27

9

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md

10 NAME OF FATHER

John W. Evans

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant  
(Address)Melvin Chase  
501 N. Mount St.

15 Filed

C. HAMPSON JONES, M.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry find that said deceased came to her death  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH was as follows:

Bilateral SalpingitisCONTRIBUTORY  
(Secondary)

(duration)

Post-operative shock

(Signed)

(duration)

Engel Ziller M. D.

(Coroner)

4/3. 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Zion Cem. Date of Burial 4/4 1928

20 UNDERTAKER

Samuel T. Hensley ADDRESS 578 W. Biddle

VERY IMPORTANT: See Instructions on reverse side of this form.

APR 3 - 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32394

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 W. Barney St.

ST., 23-31 WARD)

REGISTERED NO.

E 32394  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paulus Baumann

(a) RESIDENCE NO. 6 W. Barney St  
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos.

ST., WARD  
(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Baumann

6 DATE OF BIRTH (month, day, and year) May 30 1844

7 AGE Years 85 Months 10 Days 1 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany  
(State or country)

10 NAME OF FATHER John Baumann

11 BIRTHPLACE OF FATHER (city or town) Ger  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Mrs Baumann  
(Address) 6 W. Barney St

15 Filed 1326 HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1 1928

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1928, to April 1, 1928 that I last saw him alive on Mar 31, 1928 and that death occurred, on the date stated above, at 7 A m.  
The CAUSE OF DEATH\* was as follows:Cerebral Hemorrhage  
(duration) yrs. mos. 17 ds.CONTRIBUTORY (Secondary) Exhaustion  
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemistry  
(Signed) R. H. Campbell, M. D.  
4/2, 1928 (Address) 1644 Hancock St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL  
Western Cemetery

DATE OF BURIAL

20 UNDERTAKER

Apr 4 1928  
ADDRESS

J. F. M. Gully

130 E. Fort

B 32395

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

47 E 32395

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Battery Ave

24-33  
WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilly V. Hudson

(a) RESIDENCE NO. 1424 Battery Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William T. Hudson

6 DATE OF BIRTH (month, day, and year) Feb 10 1878

7 AGE Years 50 Months 1 Days 21 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Joun T. Long

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Sarah Day

13 BIRTHPLACE OF MOTHER (city or town) Virg. (State or country)

14 Informant William T. Hudson (Address) 1424 Battery Ave

15 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 1, 1927, to Mar 31, 1928

that I last saw her alive on Mar 31, 1928

and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Mar 12/28

Was there an autopsy?

What test confirmed diagnosis? Lab

(Signed) Wm. C. Smith, M. D.

4/2/28 (Address) 1319 Light St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Cemetery

DATE OF BURIAL

Apr 9, 1928 ADDRESS

20 UNDERTAKER

J. F. M. Gully

130 E. Fort

PR 3-1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32396

## CERTIFICATE OF DEATH.

31 E 32396

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 18-B. WARD)

## 2-FULL NAME

Irene Bruce

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No.

804 W. Saratoga st.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

1915

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

School-girl

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

North Carolina

## 10 NAME OF FATHER

Samuel Bruce

## PARENTS

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

South Carolina

## 12 MAIDEN NAME OF MOTHER

Annie Blank

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

South Carolina

## 14

Informant  
(Address)

Hospital Records

## 15

Filed

C. H. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 1st 19 28

## 17

I HEREBY CERTIFY, That I attended deceased from  
March 23, 19 28, to April 1st, 19 28.

that I last saw her alive on April 1st, 19 28,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical &amp; autopsy

(Signed) [Signature] M. D.

4-2-19 28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Mt Zion Cemetery April 4 19 28

## 20 UNDERTAKER

## ADDRESS

Adolphus Habtead

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

246  
21 E 32397

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST., 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Beulah Marshall

(a) RESIDENCE NO.

1228 Madison ST.

WARD A 2

Length of residence in city or town where death occurred

8 yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female black married

5a If married, widowed, or divorced  
HUSBAND of—  
(or) WIFE of

Joseph Marshall

6 DATE OF BIRTH (month, day, and year)

3/17/97

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

31

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Alabama

10 NAME OF FATHER

Geo. Johnson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ala.

12 MAIDEN NAME OF MOTHER

Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ala.

14

Informant  
(Address)

Records

15

Filed

G. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/1 1928

17

I HEREBY CERTIFY, That I attended deceased from  
3/19, 1928, to 4/1, 1928,

that I last saw her alive on

4/1, 1928,

and that death occurred, on the date stated above, at 942 a. m.

The CAUSE OF DEATH\* was as follows:

Myomata uteri;  
Salpingitis, chronic

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Pneumonia, broncho

(duration) yrs. mos. ds. 6

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Yes Date of 3-20-28

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

I. Ridgeway Trumble, M. D.

4-1-28 (address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Arlington

4/4 1928

20 UNDERTAKER

ADDRESS

B. Brown Knight 71218 McE



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32398

E 32398

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1810 Ashburton*)ST. *15-68* WARD *129*

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles F. Jenkins*(a) RESIDENCE. No. *1810 Ashburton*

ST. .... WARD. ....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *12* yrs. .... mos. .... ds. How long in U. S., if of foreign birth? yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Agnes M. Jenkins*6 DATE OF BIRTH (month, day, and year) *Apr. 9-1858*7 AGE Years *69* Months *11* Days *23* If LESS than 1 day, .... hrs. or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Printer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Phila. Pa*  
(State or country)10 NAME OF FATHER *John Jenkins*11 BIRTHPLACE OF FATHER (city or town) *Malis*  
(State or country)12 MAIDEN NAME OF MOTHER *Kath. Matson*13 BIRTHPLACE OF MOTHER (city or town) *Pa*  
(State or country)14 Informant *Agnes M. Jenkins*  
(Address) *1810 Ashburton*15 Filed *PR 3 - 1928* *HALLISON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 2<sup>nd</sup>* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *Mar. 2<sup>nd</sup>*, 19 *28*, to *Apr. 1<sup>st</sup>*, 19 *28*, that I last saw him alive on *Apr. 1<sup>st</sup>*, 19 *28*.and that death occurred, on the date stated above, at *4. a.* m.

The CAUSE OF DEATH\* was as follows:

*Arterio-Sclerosis, Interstitial Nephritis with Endocarditis*(duration) *4* yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Isaac E. Dickson* M. D.(Address) *3055 N. North ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Phila Pa**4/9* 19 *28*

20 UNDERTAKER

ADDRESS

*Wmeyer 1620 Ashburton*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32399

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N. Central av. 5-8 ST. 5-8 WARD)

## 2-FULL NAME William H. Gallaway

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 414 N. Central av. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of T. Larina Gallaway (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years 52 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Ind

10 NAME OF FATHER Samuel Gallaway

11 BIRTHPLACE OF FATHER (city or town) M. C. (State or country)

12 MAIDEN NAME OF MOTHER Nancy Brown 4-2, 1925 (Address) 126 Disgrace St

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Ind

14 Informant T. Larina Gallaway (Address) 414 N. Central av.

15 Filed 1928 HAMILSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1928, to Mar 31, 1928, that I last saw him alive on Mar 31, 1928, and that death occurred, on the date stated above, at 7:15 A. m. The CAUSE OF DEATH\* was as follows:

Chronic Nephritic Heart Disease

(duration) yrs. 8 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. J. Green M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

asbury cemetery apr 4, 1928

20 UNDERTAKER

ADDRESS 1681

Edward Bryan orleans st

E 32400

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

179 E 32400  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Sydenham Hospital St. 8-13 Ward)2-FULL NAME Mary Edna Nepfel(a) RESIDENCE NO. 2033 E. Mura St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days Nov 1/24  
IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md

## 10 NAME OF FATHER

Henry Nepfel

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.12 MAIDEN NAME OF MOTHER Anna May Mackley

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant Mother  
(Address)15 Filed 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2/28 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-inquiry find that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia-Accidental burns  
(Clothes caught from Oil heater)

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Measles  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) [Signature] M. D.

(Coroner)

4/3/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

where was disease contracted, if not at place of death.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Parkwood

## 20 UNDERTAKER

Richard Whaley

Date of Burial

4/4 1928ADDRESS 1620Chesapeake

Very Important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32401

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2213 Russell St.*)2-FULL NAME *Otelia T. Weimaster*(a) RESIDENCE. NO. *2213 Russell St.*

(Usual place of abode)

Length of residence in city or town where death occurred *unknown* mos.REGISTERED NO. *15-600*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

ds. How long in U. S., If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed,

or Divorced (write the word)

*Widow*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Widow*6 DATE OF BIRTH (month, day, and year) *Dec. 24<sup>th</sup> 1868*

7 AGE

Years

Months

Days

If LESS than

1 day. hrs.

or min.

*59**3**8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housekeeper.*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Self.*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Germany.*10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Germany.*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Germany.*

14

Informant  
(Address)*Joseph T. Weimaster  
Hawson St.*

R 3 - 1928

C. HANCOCK JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 2, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 23, 1928*, to date of death, that I last saw him alive on *April 2, 1928*.and that death occurred, on the date stated above, at *10 a. m.*

The CAUSE OF DEATH\* was as follows:

*Death due to  
Septicemia  
following heart trouble*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Urinal*

(Signed)

*Clarence Lee Harris, M. D.*

827 N. Harrison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Parkwood Cemetery**April 4, 1928*

20 UNDERTAKER

ADDRESS

*John Burns Sons**Hawson St.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32402

## CERTIFICATE OF DEATH.

E 32402

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1225 Ann. St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Sufczynski(a) RESIDENCE NO. 1225 Ann St. 2-4 Ward(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

16 DATE OF DEATH (month, day, and year) April 3, 1928Female White Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 3, 1928, that I last saw him alive on April 2, 1928 and that death occurred, on the date stated above, at 6 am.6 DATE OF BIRTH (month, day, and year) April 1-28

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

The CAUSE OF DEATH\* was as follows:

Acute Necrosis

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY (Secondary)

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant

(Address)

Frank Sufczynski  
1225 Ann St

15

Filed

19

C. HARRISON JONES, M. D.

P.

Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL

ADDRESS

20 UNDERTAKER

St. Stanislaus  
J. W. GzowskiDate of Burial April 3, 1928

very important. See instructions on back of certificate.

E 32403

CZERWINSKI  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32403

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1725 Bank St. 2-4 St. Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1725 Bank St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White child

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.March 28-28  
6 5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

1725 Bank St.

APR 3 - 1928 HARRY JONES, M. D.

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-3 1928

17 I HEREBY CERTIFY, That I attended deceased from 3-28-28, 19, to 4-3-28, 19, that I last saw him alive on 4-3-28, 19, and that death occurred, on the data stated above, at 4:00 p.m.

The CAUSE OF DEATH\* was as follows:

Congenital Hemiplegia

(duration) yrs. mos. 7 ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Jones, M. D.

4.1.19 (Address) 2214 E. 4th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

J. H. Jones 1930 Eastern Ave

very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32404

## CERTIFICATE OF DEATH.

188-003  
E 32404  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin St. Hops Ward)2-FULL NAME John Ripken Jr.(a) RESIDENCE NO. 2735 W. Fairmount Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)Male WhiteSingle6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 7<sup>th</sup> 1918

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

9 5 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

School Boy

9 BIRTHPLACE (city or town)

(State or country)

Balto

10 NAME OF FATHER

John Ripken Sr

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto

12 MAIDEN NAME OF MOTHER

Ethel J. Colehouse

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto

14

Informant  
(Address)John Ripken Sr  
2735 W. Fairmount Ave

15 Filed.....

APR 3 - 1928

JAMES M. D.

(Registrar)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928March 31<sup>st</sup>

17 I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, (or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry.)

And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured SkullCONTRIBUTORY  
(Secondary)Struck by auto(Signed) John B. Norton M. D.(Address) Curtis Bay,

\*State the Disease Causing Death or in deaths from Violent

Causes, state (1) Manner and Nature of Injury, (2) Whether Ac-

cidental, Suicidal, or Homicidal. (See instructions on back of certificate.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-

ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

In the

Disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial

REMOVAL

Woodlawn Cemetery Apr 3 1928

20 UNDERTAKER

Address

for Joendens Son 2173. Pac.

Very Important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32405

## CERTIFICATE OF DEATH.

178 E 32405

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 215 Cove Al 18-76 St. Ward)

## 2-FULL NAME

Mollie Hunt (Hargrave)

## (a) RESIDENCE NO.

215 Cove Alley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Negro 5 Single, Married, Widowed, or Divorced, (write the word) Divorced

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Norman Hunt

6 DATE OF BIRTH (month, day, and year)

1901

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Va

## 10 NAME OF FATHER

William Hargrave

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

## 14

Informant (Address)

S. G. Martin 116 S. Jackson St

## 15

Filed

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Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1928

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Burns of body &amp; suffocation (duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) August J. J. M. D. (duration) .....yrs. ....mos. ....ds.

4/2, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death:

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Macburn Burn 4/3 1928

20 UNDERTAKER ADDRESS

Daniel A. A. 9/6



E 32406

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32406

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 614 S. Fremont Ave 21-29 Ward)2-FULL NAME William Greer(a) RESIDENCE NO. 614 S. Fremont Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Negro 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Martha Greer6 DATE OF BIRTH (month, day, and year) 18847 AGE Years 44 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) S. C.10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14

Informant  
(Address)Martha Greer  
614 S. Fremont Ave

15 Filed

APR 3 - 1928  
HARRY JONES, M. D.  
R. J. Jones Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and (from the evidence obtained by said inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis(duration) ..... yrs. 3 mos. .... ds.CONTRIBUTORY  
(Secondary)(Signed) Agnes Zeller M. D.  
(Coroner)4/2, 1928 (Address) 2739 Canton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt Auburn Cem 4/3 - 1928  
UNDERTAKER Samuel E. Carter ADDRESS 916  
Be me

Very Important. See Instructions on Back of Certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32407

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

45 yrs. mos. ds.

ST.

WARD

129 E 32407  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Caucasian

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Charles L. Dooney

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

66

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Houseman

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

## 10 NAME OF FATHER

John J. Dooney

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Mary J. Dooney

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## 14

Informant  
(Address)Charles L. Dooney  
620 N. Guilford St.

## 15

Filed

1928

C. H. JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 2 1928

## 17

I HEREBY CERTIFY that I attended deceased from

March 15, 1928, to April 2, 1928.

that I last saw him alive on April 2, 1928.

and that death occurred, on the date stated above, at 8:25 a.m.

The CAUSE OF DEATH\* was as follows:

Indurated atherosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed)

19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOV.

## DATE OF BURIAL

## UNDERTAKER

ADDRESS

John J. Dooney  
James E. Dooney4/4/28  
916  
Beverly

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32408

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 101-7-24)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 M maiden NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

C. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32409

E 32409

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 654 George St 17-24

REGISTERED NO. W2640

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Clara Jones

(a) RESIDENCE NO. 654 George St

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 5 mos.

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Negro

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Jones

6 DATE OF BIRTH (month, day, and year) Nov 1, 1895

7 AGE 33

32 Years

Months 5

Days 1

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Frank Jones

11 BIRTHPLACE OF FATHER (city or town) West River (State or country)

12 MAIDEN NAME OF MOTHER Jennie Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14

Informant (Address) Mrs. Mary Carter

15

Filed

PR 3 - 1928

HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to April 2, 1928, that I last saw her alive on April 1, 1928, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic valvular heart disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical Examination

(Signed) Wm H. Watts, M. D.

, 19 (Address) 928 Penna an

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

M. A. Jones, M. D. Undertaker

4-3-28

ADDRESS 916

Be air



32410

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32410  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3162 Remington ave. 12-51 WARD)

## 2-FULL NAME

Sarah E. Stiffler

(a) RESIDENCE NO. 3162 Remington ave.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George M. Stiffler

6 DATE OF BIRTH (month, day, and year)

Oct. 5, 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

5

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Diven

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Meriam Sater

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

George M. Stiffler  
3162 Remington ave.

15

Filed

1928. HARRISON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 25, 1928, to March 31, 1928,

that I last saw her alive on March 31, 1928,

and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilation

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

Chronic Myocarditis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted

if not at place of death? as place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Dr. Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Pine Grove, Balto. Co. April 4, 1928

20 UNDERTAKER

E. Leroy Stiffler 125 E. North Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32411

## CERTIFICATE OF DEATH

74001  
E 32411  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Plaza Apart #2 St. 14<sup>th</sup> Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. Plaza Apart #2 Park Ave. St. Ward 14<sup>th</sup>

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteMarried5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Rice

6 DATE OF BIRTH (month, day, and year)

March 7 1860

7 AGE

Years

Months

Days 24 IF LESS than 1 day hrs. 15 or min..68 + 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.  
(State or country) Md.10 NAME OF FATHER Franklin F. Horner11 BIRTHPLACE OF FATHER (City or town) Balto.  
(State or country) Md.12 MAIDEN NAME OF MOTHER Catherine J. House13 BIRTHPLACE OF MOTHER (city or town) Balto.  
(State or country) Md.

14

Informant Mrs. Emma Rice Horner  
(Address) Plaza Apart #215 Filed 1928

19

Registrar R. H. H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 30, 1928, to Apr 1, 1928that I last saw him alive on Apr 1, 1928and that death occurred, on the date stated above, at 6:05 P.M.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis(duration) yrs. mos. 3 da.CONTRIBUTORY Arteriosclerosis  
(Secondary)(duration) 40 yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. B. Cum and Hood, M. D.4/2, 1928 (Address) 626 N. Simons St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Louisa Park Cemetery, April 3, 1928

20 UNDERTAKER

ADDRESS

John C. Mitchell & Sons 1900 Eutaw St.

very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32412

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Potomac St.

ST. 1-2 WARD)

2-FULL NAME WILLIAM GRAULING Jr.

(a) RESIDENCE No. 119 S. Potomac St.

(Usual place of abode)

Length of residence in city or town where death occurred Life, yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)  
Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

---

6 DATE OF BIRTH (month, day, and year) November 26, 1926

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

1

4

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work. None(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)

10 NAME OF FATHER William Grauling

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)

12 MAIDEN NAME OF MOTHER Julia Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)14 Informant Mrs. Julia Grauling (Mother)  
(Address) 119 S. Potomac St.

15

Filed

C. HAMMOND JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 21, 1928, to Mar 31, 1928.that I last saw him alive on Mar 31, 1928  
and that death occurred, on the date stated above, at 7.45 p. m.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lung Grauling  
(Signed) W. H. M. D.

(Address) 3015 Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL  
Baltimore Cemetery

DATE OF BURIAL

Apr. 3 1928

ADDRESS  
BALTIMORE ST  
& BROADWAY

20 UNDERTAKER

Henry Sander &amp; Sons Inc.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32413

## CERTIFICATE OF DEATH.

E 32413

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 233 Washington St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Malinowski(a) RESIDENCE NO. 233 Washington St. 2 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 1/2 yrs. — mos. — ds. How long in U. S., if of foreign birth? 1 1/2 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single16 DATE OF DEATH (month, day, and year) April 2, 1928

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

I HEREBY CERTIFY, That I attended deceased from 3-29-28, 19....., to 4-2-28, 19.....,6 DATE OF BIRTH (month, day, and year) Oct 28-27that I last saw him alive on 4-2-28, 19.....,7 AGE Years Months Days 5 4 IF LESS than 1 day.....hrs. or.....min.and that death occurred, on the date stated above, at 243a m.

8 OCCUPATION OF DECEASED

The CAUSE OF DEATH\* was as follows:

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Bronchopneumonia

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

(duration) .....yrs. ....mos. 7 ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

15 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of.....Was there an autopsy? noWhat test confirmed diagnosis? Clinical

(Signed)

4-2, 1928 (Address) 2214 E. Fitzgerald St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Rosary Cem 44- 1928

20 UNDERTAKER

ADDRESS

Stephen Halpin 1400

very important. See instructions on back of certificates.

15 Filed—1928

JAMES JONES, M.D. Registrar

For



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32414

32414

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 723 W. Mulberry St. 4-76 Ward)2-FULL NAME Harry Carter(a) RESIDENCE NO. 723 W. Mulberry St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Negro 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Carter

6 DATE OF BIRTH (month, day, and year) \_\_\_\_\_

7 AGE Years 48 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) Building  
(c) Name of employer \_\_\_\_\_9 BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) md10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) Unknown14 Informant Edward Brooks  
(Address) 723 W. Mulberry St.15 Filed 1928 HARRISON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Latent Pneumonia

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Reginald J. Allen M. D.  
(Coroner)4/2, 1928 (Address) 1273 9 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Peter's Cemetery April 4, 192820 UNDERTAKER Mr. Kate R. Williams & Son ADDRESS 322

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32415

## CERTIFICATE OF DEATH.

E 32415

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 215 Cove Alley St. 18-76 Ward)2-FULL NAME William Palmer(a) RESIDENCE NO. 215 Cove Alley St. 18-76 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 2 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Negro 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19047 AGE Years 24 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Va10 NAME OF FATHER Russell Palmer11 BIRTHPLACE OF FATHER (city or town) Va  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Va  
(State or country)14 Informant Philip Alcorn  
(Address) 831 W. Edinborough St.

PR 3 1928 HANCOCK JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry Inquest, au-  
topsy or inquiry, and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Burns of body & suffocation

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) Agnes Zeller M. D.  
(Coroner)4/3, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Auburn Bur Date of Burial 4/3 1928  
20 UNDERTAKER Daniels ADDRESS 816

very important. See instructions on back of certificate.

32416

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1804 Lorman* ST. *15-7* WARD)2. FULL NAME *Louie Mammis*(a) RESIDENCE NO. *1804 Lorman* ST.

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *Col*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Annie Mammis*6 DATE OF BIRTH (month, day, and year) *1878*

7 AGE

Years *50*Months *-*Days *-*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Labour*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14

Informant (Address) *Jas. Mammis*

15

Med

1928

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 1* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 22* 19 *28*, to *Apr 1* 19 *28*.that I last saw him alive on *Mar 31* 19 *28* and that death occurred, on the date stated above, at *10.40 A.M.*

The CAUSE OF DEATH\* was as follows:

*Acute Nephritis*

(duration)

yrs.

mos. *10*

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No*

Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Regular*(Signed) *F. E. Link*(Address) *1804 Lorman St.*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *St. Ambrose*DATE OF BURIAL *4/3-1928*20 UNDERTAKER *St. Ambrose*ADDRESS *916**Deane*

TION is very important. See instructions on back of certificate.

E 32417 HEALTH DEPARTMENT—CITY OF BALTIMORE—E 32417

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2305 Longwood* ST. *15-61* WARD) *90*2. FULL NAME *Mary J. Brebaker*(a) RESIDENCE No. *2305 Longwood* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Widowed*6 DATE OF BIRTH (month, day, and year) *July 1868*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *59 9 unknown*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)10 NAME OF FATHER *George Yockel*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Mary Kreager*13 BIRTHPLACE OF MOTHER (city or town) *MD.* (State or country)14 Informant *Miss Yockel* (Address) *2305 Longwood St*15 Filed *C. H. HAMPSON JONES, M. D.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 2 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mr. 1* to *April 2, 1928*that I last saw *her* alive on *April 2, 1928*and that death occurred, on the date stated above, at *7:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Sancho pneumonia  
complicated by heart*(duration) yrs. mos. ds. *3*18 Where was disease contracted *same* If not at place of death?(duration) yrs. mos. ds. *6*18 Where was disease contracted *same* If not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *culture*(Signed) *Edwin E. Kelly* M. D.17. 1928 (Address) *4 Somerset Road*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*New Cathedral*20 UNDERTAKER *Martin Fisher & Sons* ADDRESS *1827 N. North*

TION is very important. See instructions on back of certificates.

PR 3 - 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32418

## CERTIFICATE OF DEATH.

E 32418

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Keyser ST. 8-17 WARD)2. FULL NAME Nathan Smith(a) RESIDENCE NO. 2008 Keyser

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE C.5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of or WIFE of Grace Smith6 DATE OF BIRTH (month, day, and year) unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

about 57

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sw. Ga.10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

## 14

Informant (Address) Grace Smith  
2008 Keyser St.Filed 1928HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-1928

## 17

I HEREBY CERTIFY, That I attended deceased from 3-31-1928, to 4-1-1928,that I last saw him alive on 3-31-1928,and that death occurred, on the date stated above, at 2:45 m.

The CAUSE OF DEATH\* was as follows:

Apoplexy Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) J. Jackson, M. D.(Address) 600 N. Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

## DATE OF BURIAL

W. CabanyApr 3, 1928

## 20 UNDERTAKER

## ADDRESS

Mrs. R. G. Elliott1723 Ashland Ave



E 32420

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32420

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sinai Hospital* ST. *20-69* WARD)2-FULL NAME *Mr. Hyman Kramer*(a) RESIDENCE NO. *2124 Ashton*

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *2* mos. *2* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. *20-69* WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? *2* yrs. *2* mos. *2* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced. (write the word)

*Married*5a If married, widowed or divorced HUSBAND of (or) WIFE of *Lena Kramer*6 DATE OF BIRTH (month, day, and year) *September 1910*

7 AGE

*58*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Tailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Russian*10 NAME OF FATHER *Morris Kramer*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russian*12 MAIDEN NAME OF MOTHER *Antken*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Russian*

14

Informant (Address)

*Jack Lewis 1439 E. Balt X*

15

Filed

1928

HARRY JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/2/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *3/28/28*, 19, to *4/2/28*, 19, that I last saw him alive on *4/2/28*, 19,and that death occurred, on the date stated above, at *9:27 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Appendicitis & diffuse peritonitis*(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *3/28/28*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical Examination*(Signed) *C. H. H. H.*

M. D.

, 19 (Address) *Sinai Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Heaven Mosh Road**4/3* 19 *28*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Balt X*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32421

## CERTIFICATE OF DEATH.

E 32421

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *502 N Rose* ST. *7-10* WARD)2-FULL NAME *Floyd H Seunig Jr*(a) RESIDENCE NO. *502 N Rose*

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar 21 1925*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*3**12*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Cambridge Ma*10 NAME OF FATHER *Floyd H Seunig Jr*

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Cambridge Ma*12 MAIDEN NAME OF MOTHER *May Wallace*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*St Marys Co Md*

14

Informant (Address)

*Floyd H Seunig Jr 502 N Rose St*15 Filed *1928*

C. H. HAMILTON JONES M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 2 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 15 1928* to *April 2 1928*, that I last saw him alive on *April 2 1928*, and that death occurred, on the date stated above, at *8:25 P. M.*

The CAUSE OF DEATH\* was as follows:

*Simple Inter pneumonia*

(duration)

yrs.

mos. *16* ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. *9* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

*No* Date of *—*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Clinical*

(Signed)

*A. H. Watson*

M. D.

, 19

(Address)

*877 N. Charles St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*St Matthews Cem**4/4/1928*

20 UNDERTAKER

*John Uerich*

ADDRESS

*2908 Orleans St*



## HEALTH DEPARTMENT - CITY OF BALTIMORE

E 32422

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

129 E 32422

CITY OF BALTIMORE: (No. 2031 Eutaw Place ST. 4-70 WARD)

2-FULL NAME Bessie Kahn

(a) RESIDENCE No. 2031 Eutaw Place ST. WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob M. Kahn

6 DATE OF BIRTH (month, day, and year) Aug 10, 1858

7 AGE 69 Years 7 Months 15 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

10 NAME OF FATHER Jacob Schapiro

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant J. M. Kahn (Address) 2031 Eutaw Place

15 HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1928

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to April 2, 1928, that I last saw her alive on April 2, 1928

and that death occurred, on the date stated above, at 6.30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Hypertensive Nephritis

(duration) 5 yrs. ? mos. ds.

CONTRIBUTORY Uremic Coma (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Frank Levinson, M. D.

19 (Address) 2305 Eutaw Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

6201 BALB. Heber Cemetery 4/28/28

20 UNDERTAKER ADDRESS

Jahman &amp; Co 2432 Restoration Rd

TION is very important. See instructions on back of certificates.

PR 3 - 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32423

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Eutaw Place ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

1805 Eutaw Place

ST. WARD

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 40 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

white

Married

5a If married, widowed, or divorced

HUSBAND of  
or) WIFE of

Elias Coplan

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

57

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Russia

10 NAME OF FATHER

Abraham Potz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Hannah

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

J. Lewis  
1430 E. Balt. St.

15

Filed

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2- 19 28

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1926, to April 2, 1928, that I last saw her alive on April 2, 1928,

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH\* was as follows:

arteriosclerosis, Hypertension;  
Diabetes Mellitus, Chronic  
nephritis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed)

M. D. Lewis  
4/2, 1928 (Address) 1800 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Herring Run April 8 1928

20 UNDERTAKER

ADDRESS

J. Lewis 445 E. B. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32424

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 32424

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 S. Linwood ave 1-1 WARD)

## 2-FULL NAME

Marion V. Pentz(a) RESIDENCE NO. 909 S. Linwood ave  
(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of -6 DATE OF BIRTH (month, day, and year) Jan 5-19287 AGE Years Months Days 28 If LESS than 1 day, hrs. or min. 28

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) out

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)10 NAME OF FATHER Edw. C. Pentz11 BIRTHPLACE OF FATHER (city or town) Winchester, Md.  
(State or country)12 MAIDEN NAME OF MOTHER Aldrella Hendrick13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.  
(State or country)

14

Informant Aldrella Pentz  
(Address) 909 S. Linwood aveAPR 3 - 1928 HAMPDEN JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1928

17

I HEREBY CERTIFY, That I attended deceased from 4-7-28 to April 2, 1928, that I last saw him alive on April 1, 1928 and that death occurred, on the date stated above, at 11 A.M.  
The CAUSE OF DEATH\* was as follows:  
Acute RheumatismCONTRIBUTORY (Secondary) Acute Rheumatism  
(duration) yrs. mos. ds. 718 Where was disease contracted if not at place of death? unknownDid an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? pending(Signed) J. H. Hendrick M. D.(Address) 600 N. North St.

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel CemeteryApr 4 1928

20 UNDERTAKER

ADDRESS

George N. Zinkler1737 E. Egan St

## E 32425 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5107 O'Donnell

ST. 26-37 WARD)

REGISTERED NO. 32425

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Zimmerman

(a) RESIDENCE NO. 5107 O'Donnell

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 80 yrs. mos.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 80 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Margaret Zimmerman

6 DATE OF BIRTH (month, day, and year) July 5-1842

7 AGE Years 85 Months 8 Days 28 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Carpenter (Retired)

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Fred. Zimmerman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not known

14 Informant Frederick Zimmerman

(Address) 5107 O'Donnell St.

15 Filed 1928 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 30 1928, to April 2 1928,

that I last saw him alive on April 2 1928,

and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Harace B. Titlow M. D.

4/3, 1928 (Address) 315 S. Highland Ave

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Carmel Cemetery

April 5 1928

20 UNDERTAKER

George W. Zirkler

ADDRESS 1737 E. Cogan St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32426

## CERTIFICATE OF DEATH.

49 E 32426  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1521 Ellamont Ave.

2-FULL NAME Ida B. Hoffman,

(a) RESIDENCE NO. 1521 Ellamont Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 6 ds.

ST. WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William G. Hoffman,

6 DATE OF BIRTH (month, day, and year) October 26, 1855

7 AGE Years 72 Months 5 Days 6 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Lezziah Powell,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Burlington N.J.

12 MAIDEN NAME OF MOTHER Anita Briscoe.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md.

14 Informant Miss Ethel B. Hoffman, (Address) 1521 Ellamont Ave.

15 Filed 1928 C. HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 2 1928

17 I HEREBY CERTIFY, That I attended deceased from - 2 - 1926 to Apr 2 - 1928, that I last saw her alive on Apr 2, 1928, and that death occurred, on the date stated above, at 3 45 P. M. The CAUSE OF DEATH\* was as follows:

Carcinoma Bladder (Urinary)

(duration) 2 yrs. - mos. - ds.

## CONTRIBUTORY (Secondary)

(duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) M. B. K. M. D.

4/3 1928 (Address) 626 N. Gilman St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Woodlawn  
Geo W Little

TION is very important. See instructions on back of certificates.

E 32427

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

38 E 32427

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 919 Plum al St. 2831 Ward)2-FULL NAME Wm H. Jones(a) RESIDENCE NO. 919 Plum al St. 2831 Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 Color or Race

Col.

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Iida Jones6 DATE OF BIRTH (month, day, and year) 11/07/18

7 AGE

Years

Months

Days

IF LESS than  
1 day 0 hrs.  
or 0 min..

55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

(c) Name of employer

Serious &amp; Zenith

9 BIRTHPLACE (city or town)  
(State or country)

Md.

10 NAME OF FATHER Wm H. Jones11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

Md.

12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

14

Informant  
(Address)Lucy Brasley  
908 S Sharp St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31 19 2817 I HEREBY CERTIFY, That I attended deceased from 3/28/28 to 3/31/28, 19 28, that I last saw him alive on 3/31/28, 19 28, and that death occurred, on the date stated above, at 11:07 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY

(Secondary)

Arteriosclerosis  
(duration) 6 yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Clinical

(Signed)

John H. Jones, M. D.  
4/3/28 Address 908 S Sharp St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt Auburn Cemetery, April 4, 1928  
20 UNDERTAKER  
Ernest Pres 11920 Hemmett St.

PR 3-1928

C. HAYES JONES, M. D.  
Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32428 DEATH

129 E 32428

City of BALTIMORE: (No. 4218 Hamilton Ave. 77-42 Ward)

2-FULL NAME Barbara Horak Jerabek

(a) RESIDENCE NO. 4218 Hamilton Ave. St. Ward

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 60 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Joseph Jerabek

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

77

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Housework

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Austria

## 10 NAME OF FATHER

Anton Jerger

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Austria

## 12 MAIDEN NAME OF MOTHER

Not known

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Austria

14

Informant

Frank Horak

(Address)

4218 Hamilton Ave

15

Filed

3-1928

C. H. HAMERSON JONES, M. D.

R. H. Jones

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

Mar 31

17

I HEREBY CERTIFY, That I attended deceased from

March 26, 1928, to March 27, 1928,

that I last saw him alive on March 26, 1928,

and that death occurred, on the date stated above, at 4:40 p.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction  
ruptured, aneurysmCONTRIBUTORY  
(Secondary)

(duration) ..... yrs. .... mos. .... ds.

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

10

Date of

Was there an autopsy?

10

What test confirmed diagnosis?

(Signed)

J. H. Jones, M. D.  
19-28-28  
State the Disease Causing Death, or in Death from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Holy Redeemer

April 4, 1928

20 UNDERTAKER

ADDRESS

Frank Croach &amp; Son

1906 1/2 Broadway

Very Important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32429

## CERTIFICATE OF DEATH.

188-003 ✓  
E 32429

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital Ward)2-FULL NAME Herman H. Zang(a) RESIDENCE NO. 1002 N. Rutland Ave St. 8-17 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Anna C. Lang

6 DATE OF BIRTH (month, day, and year)

Aug 28-18797 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
48 7 5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Schludderberg Co

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

10 NAME OF FATHER

Louis Zang

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Mary G. Bubert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant (Address)

Wife

15 Filed.....

19

BALTIMORE, MD. REGISTRAR

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Intracranial Hemorrhage.  
Struck by automobile at Chester & McElderry Sts.CONTRIBUTORY (Secondary) Autopsy at Hospital(Signed) J. J. Porter M. D. (Coroner)

4/3/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Gravard Hill Cemetery April 19 28  
UNDERTAKER Henry Lutz 77 Broadway

OF DEATH IN PAIR TERMS, See instructions on back of certificate.



E 32430

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32430

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

Colonial Hospital

CITY OF BALTIMORE: (No.

1122 N. Mount St.

WARD)

2. FULL NAME

James Roberts

(a) RESIDENCE NO.

3027 E. Balt

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

56 yrs. 10 mos. 16 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Hester Roberts

6 DATE OF BIRTH (month, day, and year)

May 17, 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

10

16

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Paint

(c) Name of employer

Wm. H. E. Chase

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

James Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Donthorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

James Roberts 3027 E. Balt

15

1928

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 2, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 26, 1928, to

April 2, 1928,

that I last saw him alive on

April 2, 1928,

and that death occurred, on the date stated above, at

4:12 p. m.

The CAUSE OF DEATH\* was as follows:

Thrombosis of inferior cerebellar tract &amp; nucleus ambiguous syphilitic type

(duration)

yrs.

mos

5 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos

1 ds.

18 Where was disease contracted if not at place of death?

D

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clin. data

(Signed)

J. H. Schlegel

M. D.

, 19

(Address)

3027 E. Balt

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

BALTIMORE

April 4, 1928

20 UNDERTAKER

J. G. Moran

E. Balt

TION is very important. See instructions on back of certificates.

E 32431

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32431

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 N. Glover St. - 6-10

ST. 6-10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years 57

Months 7

Days 7

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

3-1928

G. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1928

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1928, to April 1, 1928, that I last saw him alive on April 1, 1928,

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH\* was as follows:

Pleur. Pneumonia - l. - Done.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Jones, M. D.

19 (Address) 125 S. Maryland

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

X UNDERTAKER

ADDRESS 3000

Balt. Cemetery 4/4 1928 J. H. Jones

E 32432

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32432

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1130 Mosher* St. *16-23* Ward)

Registered No. ....

2-FULL NAME *Warren S. Hayman*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *1130 Mosher St.*

St. .... Ward. ....

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*M*

4-COLOR OR RACE,

*C*5-Single, Married, Widowed, or Divorced, (Write the word.) *X*

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) *3-31-28*

7-AGE,

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work, ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer, ....

9-BIRTHPLACE (city or town), (State or Country), *1130 Mosher St.*10-NAME OF FATHER, *Warren S. Hayman*11-BIRTHPLACE OF FATHER (city or town), (State or Country), *Salisbury Md.*12-MAIDEN NAME OF MOTHER, *Julia B. Clark*13-BIRTHPLACE OF MOTHER (city or town), (State or Country), *Balto. Md.*

14-

(Informant) *Julia B. Hayman*(Address) *1130 Mosher St.*

15-

Filed *1928**C. HAMPSON JONES, M. D.*

Regl-trar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). *4-1-28*17- I HEREBY CERTIFY, That I attended deceased from *3-31-1928* to *4-1-1928*that I last saw him alive on *4-1-1928*and that death occurred, on the date stated above, at *3:15 P.M.*

The CAUSE OF DEATH\* was as follows:

*Premature Birth*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *C. Mansell Lawrence, M. D.*

19

(Address) *1232 W Mosher St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

*JOHN S. HOPKINS HOSPITAL**APR 2 - 1928*

Instructions on back of certificate.

E 32433

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32433

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 N. Carey ST. 19-26 WARD)2. FULL NAME Alma Grace Moran(a) RESIDENCE NO. 322 N. Carey ST.,

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Ellen Moran11 BIRTHPLACE OF FATHER (city or town) (State or country) N Va12 MAIDEN NAME OF MOTHER May Williams13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chicago Ill

14

Informant (Address)

G. HAMPSON JONES, M. D.15 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1928 to April 2, 1928that I last saw him alive on April 1, 1928and that death occurred, on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH\* was as follows:

Congenital atelectasis, Premature birth 17 mos(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Plain data  
(Signed) Leitch, M. D.19 (Address) 3034 E. Baltimore St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health,ADDRESS 1928

TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32434

E 32434

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

M. Gen. Hospital

REGISTERED NO.

City of BALTIMORE: (No.

905 Pindle Ct. 17-24

(If death occurred in a hospital or institution, give its NAME of street and number and fill out No. 18.)

2-FULL NAME

Chas. Rutland Lane (or Lohmeyer)

(a) RESIDENCE NO.

905 Pindle Ct. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

Cauc

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 1 - 1922

7 AGE

Years

Months

Days 29

IF LESS than 1 day.....hrs. or.....min.

5 5 30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

10 NAME OF FATHER

Arthur Lohmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Petram

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mary Lohmeyer 905 Pindle Ct.

15 Filed

C. HAMPTON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 30 1928

17

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, au-

And that said deceased came to his death (Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured Skull

CONTRIBUTORY (Secondary)

Fell off Roof

(Signed)

19

(Address)

F. B. Jones, M. D. 1011 Ave. 10

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

UNIVERSITY OF MARYLAND

19

20 UNDERTAKER

Office of Health

ADDRESS

APR 3 - 1928

E 32435

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32435

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *12-50* WARD)2-FULL NAME *Betty Patterson*(a) RESIDENCE No. *342 E. 23 1/2 St*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Mar. 25, 1928*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER *Robert Patterson*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Blenford*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

JOHN HOPKINS HOSPITAL

HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 26 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*3-25*, 19*28*, to *3-26*, 19*28*,that I last saw him alive on *3-26*, 19*28*and that death occurred, on the date stated above, at *7:10 A. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage  
(Birth Injury)*(duration) yrs. mos. *12* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed)

M. D.

*4-2-1928* (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



E 32437

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32437

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

BALTIMORE CITY HOSPITAL

ST., 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Samuel Myers

(a) RESIDENCE No. 926 E. Sunward

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred ? yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of or WIFE of

?

6 DATE OF BIRTH (month, day, and year)

?

7 AGE

68

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

640

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Washington D. C.

10 NAME OF FATHER

Dennis Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Perryman, Maryland

12 MAIDEN NAME OF MOTHER

Married Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Reveries

15

Filed 1928, 19

G. HANSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/31/1928

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 29, 1928, to Mar. 31, 1928

that I last saw him alive on Mar. 31, 1928

and that death occurred, on the date stated above, at 10:00 A. M.

The CAUSE OF DEATH\* was as follows:

Vincent's angina  
Generalized Vincent's  
infection

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General &amp; Sal

(Signed) C. J. Holmes, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Baltimore Health

APR 3 - 1928

Pop. Wm. E. Woodall



E 32438

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32438

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 17-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis White(a) RESIDENCE NO. 8 Nassau St. Mission  
(Usual place of abode)

WARD

Length of residence in city or town where death occurred 3 yrs.  mos.  ds. How long in U. S., if of foreign birth?  yrs.  mos.  ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) ?7 AGE Years 50 Months  Days  If LESS than 1 day,  hrs. or  min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England10 NAME OF FATHER Francis White11 BIRTHPLACE OF FATHER (city or town) (State or country) England12 MAIDEN NAME OF MOTHER Mary Swenden13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14

Informant (Address) W. H. H. H.

15

File 1928

19

CLAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/192817 I HEREBY CERTIFY, That I attended deceased from Mar. 30, 1928, to Apr. 3, 1928, that I last saw him live on Apr. 3, 1928, and that death occurred, on the date stated above, at 4:00 A. M.

The CAUSE OF DEATH\* was as follows:

Subs. pneumonia(duration)  yrs.  mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration)  yrs.  mos.  ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Subs.(Signed) C. J. H. H. H. M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32439

## CERTIFICATE OF DEATH.

90 32439

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 845 Hellington St. 13-52 ST. WARD)

## 2-FULL NAME

John F. Cooke

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 845 Hellington St. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Emma Cooke

6 DATE OF BIRTH (month, day, and year) July 28-1855

7 AGE Years 72 Months 8 Days 54 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Vernon - Hodgson Mills Inc.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

10 NAME OF FATHER John F. Cooke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Virginia Busch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Mrs. Emma Cooke (Address) 845 Hellington St. W.

15 Filled by R. H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2-1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 15-1928 to April 1-1928; that I last saw him alive on April 1-1928; and that death occurred, on the date stated above, at 7:45 p. m.

The CAUSE OF DEATH\* was as follows:

myocardial infarction  
myocarditis chronic

CONTRIBUTORY (Secondary) Prostate by prostatic (duration) yrs. mos. 5 ds.

18 Where was disease contracted (duration) 5 yrs. mos. ds. if not at place of death?

Did an operation precede death? Yes Date of Feb 15-28

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James S. Ashurst, M. D.

4-3-1928 (Address) 4012 Lane Hyde Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Morris F. Burgee 361 Hale Road

32440

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32440

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 Fourth St. Brooklyn)

ST. 25 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 25 Fourth St. (Brooklyn)

(Usual place of abode)

ST. 25 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joanna E. Gray

6 DATE OF BIRTH (month, day, and year)

March 12-1840

7 AGE

88

Years

Months

Days

20

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer)

M.P. Church

(c) Name of employer

Retired 20 years

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

John Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Lydia Fyfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pennsylvania

14

Informant (Address)

Dr. J. J. Gray 25 Fourth St. Brooklyn

15

Filed

G. HANSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year)

April 1, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 20, 1928, to April 1, 1928.

that I last saw him alive on March 31, 1928.

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumo - Pneumonia

(duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) M. D.

19 (Address) 886 Pennington Ave

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

1 Cedar Hill April 4, 1928

UNDERTAKER ADDRESS

Horace F. Burgee 3601 Falls Road

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32441

## CERTIFICATE OF DEATH.

E 32441

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *7-48* WARD)2. FULL NAME *Bertha M. Norris*(a) RESIDENCE No. *629 Ravenswood Ave* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Howard T. Norris*6 DATE OF BIRTH (month, day, and year) *Dec 9, 1890*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*37**3**23*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Wm W. Ashburn*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md.*12 MAIDEN NAME OF MOTHER *Frances J. Ashburn*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md.*

14

Informant (Address) *Howard T. Norris 629 Ravenswood Ave*

15

Filed *1928*, 19Registrar *G. CLAMSON JONES, M.D.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 2, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 15, 1928*, to *April 2, 1928*,that I last saw him alive on *April 2, 1928*,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Chronic nephritis  
Renal Hypertension*(duration) *13* yrs. mos. ds.CONTRIBUTORY (Secondary) *Uræmia*(duration) yrs. mos. *10* yrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Clinical & autopsy*(Signed) *H. T. Norris* M. D., 19 (Address) *5600 York Rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*London Park*  
UNDERTAKER *J. M. Cook*ADDRESS *502 E. North Ave*



E 32442

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32442

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 5-8 WARD)

2-FULL NAME

Charles Corso

(a) RESIDENCE No.

528 Forrest

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Batina Corso

6 DATE OF BIRTH (month, day, and year)

Feb 14, 1884

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

1

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Italy

10 NAME OF FATHER

Louis Corso

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Batina Corso

15

Filed 1928, 19

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1928 to April 1, 1928, that I last saw him alive on April 1, 1928, and that death occurred, on the date stated above, at 10:10 P.m.

The CAUSE OF DEATH was as follows:

Cellulitis of face

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Probable carcinoma sinus thrombosis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. W. Peake, M.D.

, 19 (Address) University Hospital

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Redeemer

4/4 1928

UNDERTAKER

ADDRESS

J. H. Cook

202 E. North Ave

212 E 32443

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 1-001 E 32443

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 79 ST. 79 WARD)

## 2. FULL NAME

Guy Garrison

## (a) RESIDENCE NO.

P.O. - 263 Sparrow Pt. - WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Sept 18 - 1911

## 7 AGE

Years

17

Months

6

Days

14

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

mill worker

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Penn -

## 10 NAME OF FATHER

Frank Garrison Pa -

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

Records -

## 15

Filed

1928

J. H. HARTMAN, JR., M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 2 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar. 25, 1928, to April 2, 1928.

that I last saw him alive on April 2, 1928.

and that death occurred, on the date stated above, at 9:54 a.m.

The CAUSE OF DEATH\* was as follows:

Typhoid fever.

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Blood culture

(Signed)

L. M. M. D.

4-2, 1928 (Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Tarentum Pa

## UNDERTAKER

Wm Cook

## DATE OF BURIAL

4/3 1928

## ADDRESS

502 E Vall

E 32444 HEALTH DEPARTMENT—CITY OF BALTIMORE E 32444

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Sinai Hospital*CITY OF BALTIMORE: (No. *7-13*)ST. *7-13* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Maud Hall*(a) RESIDENCE NO. *Lock Haven, Pa.*

(Usual place of abode)

ST. *7-13* WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*W.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*A. A. Hall*

6 DATE OF BIRTH (month, day, and year)

*Dec 16, 1864*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*63**3**16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Pa*

10 NAME OF FATHER

*William Packer*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Pa*

12 MAIDEN NAME OF MOTHER

*Sarah (Unknown)*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Pa*

14

Informant (Address)

*Mr. S. Hall, Cape Charles Va.*

15

File

*FRANKSON JONES M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 2, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 20, 1928, to April 2, 1928.*that I last saw *her* alive on *April 2, 1928*and that death occurred, on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*

(duration)

yrs. *2*

mos.

ds.

CONTRIBUTORY (Secondary)

*Broncho pneumonia*

(duration)

yrs.

mos. *4*

ds.

18 Where was disease contracted if not at place of death?

*Same*

Did an operation precede death?

*no*

Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Physical Signs*

(Signed)

*Milton Sharp*

M. D.

, 19

(Address)

*Sinai Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*Lock Haven, Pa.**4/3, 1928*

UNDERTAKER

*William Cook*

ADDRESS

*502 E. North*

TION is very important See instructions on back of certificates.

E 32445

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32445

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *JOHNS HOPKINS HOSPITAL*

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST., *7-9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Michael Paisie*(a) RESIDENCE NO. *Marlin Ferry*ST., *Ohio* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Sept. 15, 1890.*

6 DATE OF BIRTH (month, day, and year)

*1890*

7 AGE

Years

Months

Days

If LESS than  
1 day hrs.  
or min.*37**6**17**18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Greece*

10 NAME OF FATHER

*Bill Paisie*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Greece*

12 MAIDEN NAME OF MOTHER

*Irene*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)*Records -*

15

Filing

*1928 C. HAMMON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 2 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*April 1, 1928, to April 2, 1928.*  
that I last saw him alive on *April 2, 1928.*  
and that death occurred, on the date stated above, at *4:30 p. m.*

The CAUSE OF DEATH\* was as follows:

*Addison's Disease*(duration) yrs. *3* mos. ds.CONTRIBUTORY  
(Secondary)*Pulmonary tuberculosis*  
(duration) yrs. *4* mos. ds.18 Where was disease contracted  
if not at place of death?*Not known*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy.*

(Signed)

*James Bradley*

M. D.

4-2, 1928 (Address)

*Johns Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Marlin Ferry, Ohio**4/3/28.*

20 UNDERTAKER

ADDRESS

*George J. Tully 1735 Harford*

TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32446

## CERTIFICATE OF DEATH.

E 32446

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 7-9 Ward)2-FULL NAME Geraldine Presbury(a) RESIDENCE NO. Belair, Md. St.  Ward 

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female Col single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....none(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

Md.

10 NAME OF FATHER

Herbert Presbury

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

12 MAIDEN NAME OF MOTHER Geraldine

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

14

Informant  
(Address)

Hospital Records

15 Filed.....

G. HAMPTON JONES, Registrar

1928

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

Apr 3/28

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-inquiry.....and that said deceased came to her death  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumococcic Meningitis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) [Signature] M. D.

(Coroner)

4/3/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVALBurlington Md April 5, 1928

20 UNDERTAKER

Dean Foster Bel Air Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2125-78  
E 32447

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

\* gife 32447

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.

WARD)

## 2. FULL NAME

Bessie Kretschmar

(a) RESIDENCE No.

Hel Dale

(Usual place of abode)

ST.

WARD

Texas

Length of residence in city or town where death occurred

yrs.

mos.

8

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Max

6 DATE OF BIRTH (month, day, and year)

April 3, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Texas

10 NAME OF FATHER

Leo Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Texas

12 MAIDEN NAME OF MOTHER

Sally Cherni

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Texas

14

Informant (Address)

Records

15

Filed

G. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 3, 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 28, 1928, to April 3, 1928, that I last saw her alive on April 3, 1928, and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH\* was as follows:

Brain Tumor - Cerebellum  
Stroma - benign

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

Yes

Date of

4/3/28

Was there an autopsy?

Yes

What test confirmed diagnosis?

Clinical &amp; Operative

(Signed)

Lynne M. M. D.

M. D.

4/3/28 (Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Austin Tex

DATE OF BURIAL

4/3/28

20 UNDERTAKER

Joseph Ahrens

ADDRESS

221 Bway

TION is very important. See instructions on back of certificate.

E 32448

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32448

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2809 Orleans*)ST. *6-11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Frieda Rodka*(a) RESIDENCE No. *2809 Orleans*  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos.ds. How long in U. S., if of foreign birth? *60* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widow*5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of*William Rodka*6 DATE OF BIRTH (month, day, and year) *Jan. 25, 1842*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*86 2 8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Germany*

10 NAME OF FATHER

*Bernard T.*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Not Known*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant

*Emma Rodke*

(Address)

*2809 Orleans St.*

15

File

*1928**G. HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/2/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*3/28/28*, 19, to *4/2/28*, 19that I last saw her alive on *4/2/28*, 19and that death occurred, on the date stated above, at *4:10 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage  
Paralysis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Alfred Sage*

M. D.

(Address)

*709 N. B. St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Lorraine Cemetery**April 4, 1928*

20 UNDERTAKER

ADDRESS

*Mr. L. Miller & Son**237 E. Jefferson St.*

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32449

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2500 Electric Co. St., Ward 11)2-FULL NAME Roy C. Grossnickle(a) RESIDENCE NO. 5502 Merville Ave St., Ward 11Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO. 90 E 32449

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Jessie M. Grossnickle (or) WIFE of6 DATE OF BIRTH (month, day, and year) Oct. 6 - 18847 AGE Years 43 Months 5 Days 26 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Maryland10 NAME OF FATHER Cyrus L. Grossnickle11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Jessie M. Borrows13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Mrs. Roy C. Grossnickle (Address) 5502 Merville Ave City15 1928 C. HAMPTON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) on the day stated above, and that said deceased came to death

The CAUSE OF DEATH\* was as follows:

Calculus  
Disease of  
Heart  
(duration) 1 yrs. 1 mos. 1 ds.

## CONTRIBUTORY (Secondary)

(Signed) John H. Borrows (Coroner) M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Edmond Ave, Md Date of Burial Apr 5 - 192820 UNDERTAKER Meadow Branch Cemetery ADDRESS 6. M. Matty, Hinfield, Md.

Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32450

## CERTIFICATE OF DEATH.

18<sup>th</sup> E 32450

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (NO.

207 Lambeth Road 12-44

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Julia Ford Seney

## (a) RESIDENCE NO.

207 Lambeth Road

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

10 yrs. 0 mos. 0 ds.

How long in U. S., if of foreign birth?

20 yrs. 6 mos. 4 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

Female White

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Robert N. Seney

## 6 DATE OF BIRTH (month, day, and year)

Sept-30-1877

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

50

6

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town)  
(State or country)Cincinnati  
Ohio

## 10 NAME OF FATHER

Augustus C. Ford

## 11 BIRTHPLACE OF FATHER (city or town)

Cincinnati

(State or country)

Indiana Ohio

## 12 MAIDEN NAME OF MOTHER

Ophie Compton

## 13 BIRTHPLACE OF MOTHER (city or town)

Cincinnati

(State or country)

Ohio

## 14

Informant  
(Address)Mr Robert N. Seney - (husband)  
207 Lambeth Road

## 15

Filed

1928

192

C. HAMPTON JONES, M.  
R. H. Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

4/3 1928

## 17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry

find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Drowning in  
Bathtub in HouseCONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(Signed)

(duration) yrs. mos. ds.

(Address) 7632 Dandridge

State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or  
Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Cincinnati Ohio April 7 1928

## 20 UNDERTAKER

ADDRESS

Stewart McDonald Balto.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32451

## CERTIFICATE OF DEATH. X 99-001

E 32451

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 Warrenton Road, 27-49 ST. WARD)

## 2-FULL NAME Edith Turner Schley

(a) RESIDENCE No. 40 Warrenton Road ST.

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 0 ds.

How long in U. S., if of foreign birth? 56 yrs. 1 mos. 19 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD Colorado Springs Rd.

(If non-resident give city or town and state)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Chaloner B. Schley

6 DATE OF BIRTH (month, day, and year) Feb 14/1873

7 AGE 56 Years 1 Months 19 Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Brooklyn - N.Y. (State or country)

10 NAME OF FATHER Emory S. Turner

11 BIRTHPLACE OF FATHER (city or town) unknown

(State or country) United States

12 MAIDEN NAME OF MOTHER Mary Boyle

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country) New York State

14

Informant Mrs. Marie T. Gairt (Sister)

(Address) Albany - N.Y.

15

Filed 1028

19

HAMMOND JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1928

17

I HEREBY CERTIFY, That I attended deceased from March 3rd, 1928, to April 3rd, 1928.

that I last saw her alive on April 3rd, 1928, and that death occurred, on the date stated above, at 3:00 a. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no

Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) J. A. Chetani

M. D.

43rd 1928 (Address) 300 Walnut St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Kensico, N.Y.

April 5/1928

20 UNDERTAKER

ADDRESS

Stewart Memorial Co. Balto.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32452

## CERTIFICATE OF DEATH.

90 E 32452

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 10 Pearl St. 425 Ward)

2-FULL NAME Frederick G. Oelmann

(a) RESIDENCE NO. 10 Pearl St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. M. Oelmann

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1863

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 64 5 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City.

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Fred. Oelmann

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Dora Dettring

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs. M. Oelmann (Address) 10 Pearl St.

3-1928 G. HAMPSON JONES, M. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1928 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocardial Insufficiency

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) Eugene J. Zeller, M. D. (Coroner)

4/3/1928 (Address) 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death!

Former or usual residence.....

16 PLACE OF BURIAL, CREMATION OR REMOVAL London PK Cem. Date of Burial 4/4/28

## 20 UNDERTAKER

Geo Leimbach

Signature

E 32453

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32453

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 S Bond St. 2-4 WARD)

2-FULL NAME Mary W. Kasprzyk

(a) RESIDENCE NO. 703 S Bond St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 7 1927

7 AGE Years Months Days 25 If LESS than 1 day, hrs or min. 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER Walter Kasprzyk

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER Mary Brolinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14 Informant Mary Kasprzyk (Address) 703 S Bond St.

15 3-1928 C. HAMPTON JONES, M. D. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1928

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 2, 1928, that I last saw him alive on April 2, 1928, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) Cordis Palsy (duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

4/3/28 Signed: William J. Rydman, M. D. (Address) 800 E. ...

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Holy Rosary Cemetery April 7 1928

20 UNDERTAKER

John M. Weber 401 S. Chester St.

TION is very important See instructions on back of certificates.



E 32454

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32454

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Aliceanna St. ST. 3-4 WARD)

2-FULL NAME Tadeusz Grabowski

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1614 Aliceanna St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 1924

7 AGE Years Months Days 17 If LESS than 1 day, hrs or min. 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER Frank Grabowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER Antomina Dzieza

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14 Informant Antomina Grabowski

(Address) 1614 Aliceanna St.

15 C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1928

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1928, to April 2, 1928, that I last saw him alive on April 2, 1928, and that death occurred, on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH\* was as follows:

Measles

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Andrew Kusunowski, M. D.

4/3/1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Holy Rosary Cem April 4 1928

20 UNDERTAKER ADDRESS

John M. Weber 4012 Chester

TION is very important See instructions on back of certificates.

E 32455

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32455

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Simi Hospital 11-25* ST. *11-25* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

## WARD

Length of residence in city or town where death occurred *lifetime* yrs. *lifetime* mos. *lifetime* ds. Now long in U. S., if of foreign birth? yrs. *lifetime* mos. *lifetime* ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

*male**white**single*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant  
(Address)

## 15

Filed

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-3* 19 *28*

## 17

I HEREBY CERTIFY, That I attended deceased from

*3-11*, 19 *28*, to *4-3*, 19 *28*.that I last saw him alive on *4-3*, 19 *28*and that death occurred, on the date stated above, at *2:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*myocardial failure  
Streptococcus septicemia*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *yes*What test confirmed diagnosis? *autopsy*

(Signed)

*Harry Weinstock*

M. D.

19 (Address)

*Simi Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*Balt. Heb. Cem.**4/4/28*

## 20 UNDERTAKER

ADDRESS

*David Sondheim**1120 W. Mt. Royal Ave*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

E 32456

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32456

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

South Balt. Gen. Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No.)

ST. 33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James King

(a) RESIDENCE NO.

Bowie Race Track

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

yrs.

mos.

20

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 5, 1873

7 AGE

Years

Months

Days

About 45?

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Groom

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Thomas King

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Corp Records

15

1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2-1928

17

I HEREBY CERTIFY, That I attended deceased from 3-31-1928, to 4-2-1928.

that I last saw him live on 4-2-1928.

and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH\* was as follows:

Coronary failure

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4 ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

E. Fleming, M. D.

19 (Address)

So. Balt. Gen. Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

J. J. Anderson

4/5 1928  
131 E. High St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32457

## CERTIFICATE OF DEATH.

66 E 32457  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 421 Glen Edwards St. Ward 12)2-FULL NAME Charles R Price(a) RESIDENCE NO. 421 Glen Edwards St. Ward 12

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Price6 DATE OF BIRTH (month, day, and year) Feb 4, 19047 AGE Years 24 Months 1 Days 27 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.  
(State or country)10 NAME OF FATHER Charles Price11 BIRTHPLACE OF FATHER (city or town) unknown  
(State or country)12 MAIDEN NAME OF MOTHER Margaret Williams13 BIRTHPLACE OF MOTHER (city or town) unknown  
(State or country)14 Informant Margaret Price  
(Address) 2150 Oak St.15 Filled G. HAMPTON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (inquest, autopsy or inquiry)thereon and from the evidence obtained by said inquest (inquest, autopsy or inquiry) find that said deceased came this death on the day stated above.

The CAUSE OF DEATH\* was as follows:

acute alcoholism  
(duration) ..... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

(Signed) J. H. Hoshier M. D.  
(Coroner)4/2, 1928 (Address) 2622 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Mary's Hospital 1928  
20 UNDERTAKER Chenoweth ADDRESS 3140

Non should be carefully supplied. All should be stated. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

PR 4 - 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32458

## CERTIFICATE OF DEATH.

E 32458

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 633 Wayne ST. 22-30 WARD)

## 2. FULL NAME

(a) RESIDENCE No. 633 Wayne

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced, (write the word)

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 1928 to March 1, 1928, that I last saw him alive on April 1, 1928, and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH\* was as follows:

Gastric Cancer

CONTRIBUTORY (Secondary) (duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic signs (Signed) Charles A. Fowler, M. D.

319 24 (Address) 712 S. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR CE.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 32459

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32459

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Orleans

## 2-FULL NAME

Ethel Caldwell

## (a) RESIDENCE NO.

1514 Orleans

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 COLOR OR RACE

C

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan ? 1917

## 7 AGE

Years 11

Months 3

Days -

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

School child

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

N.C.

## 10 NAME OF FATHER

Edward Caldwell

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

N.C.

## 12 MAIDEN NAME OF MOTHER

Nannie Huff

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

N.C.

## 14

Informant  
(Address)Edward Caldwell (father)  
1514 Orleans St.

## 15

File

APR 4 - 1928 HANCOCK JONES, M. D.  
Registrar

ST. 6-9 WARD

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1928

17 I HEREBY CERTIFY, That I attended deceased from  
March 25, 1928, to April 1, 1928,  
that I last saw him alive on March 25, 1928,  
and that death occurred, on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death?

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Physical

(Signed)

4/2, 1928 (Address)

R. J. H. Jones, M. D.

1429 E. Monument

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Ising Am. Co.

Robert T. Williams 1515 N. E.

April 4, 1928

514 N. E.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32460

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 658 Vine -

## 2-FULL NAME Elizabeth Mears

(a) RESIDENCE NO. 658 Vine

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. - mos. - ds.

ST. 4-25 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Mears

6 DATE OF BIRTH (month, day, and year) Aug-18-1884

7 AGE

Years 38

Months 7

Days 13

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. W. J. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co. Virginia

10 NAME OF FATHER Cal Berans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co. Virginia

12 MAIDEN NAME OF MOTHER Miss Ariston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac Co. Virginia

14

Informant (Address) 658 Vine St.

15

Filed

APR 4 - 1928 HAMPTON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April - 1 1928

17 I HEREBY CERTIFY, That I attended deceased from June - 10 1926 to Apr - 1 1928, that I last saw him alive on Mar - 31 1928, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Embolism

CONTRIBUTORY (duration) yrs. mos. ds. Arterio Sclerosis Chronic Hypertension

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hypertension Albumin++

(Signed) David J. Mearns M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Burial Cemetery

ADDRESS

1515 M. E. Day St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32461

## CERTIFICATE OF DEATH.

E 32461

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1518 E. Fayette St. 6-9 Ward)

## 2-FULL NAME

Cleaves Chatham

## (a) RESIDENCE NO.

1518 E. Fayette

St. Ward

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	S

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year)  
February 22/1918

7 AGE	Years	Months	Days	10	IF LESS than 1 day.....hrs. or.....min.
	10	1	11		

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

South Carolina

## 10 NAME OF FATHER

John Chatham

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

S.C.

## 12 MAIDEN NAME OF MOTHER

Carrie Myers

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

S.C.

## 14

Informant Mother  
(Address)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Bronchopneumonia

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Measles  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) J. H. Jones, M. D.  
(Coroner)

4/4/28 (Address) 503 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. ....mos. ....ds. In the State .....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

APR 4 - 1928 HAMMON JONES, M.

Registrar

Ashby Cemetery  
Robert M. Jones 1515 11th & Elder St

tion should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS MARRIAGE STATEMENT OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32462

## CERTIFICATE OF DEATH.

90 E 32462

1-PLACE OF DEATH

Sinai Hospital

CITY OF BALTIMORE: (No.

ST. 8-12 WARD)

2-FULL NAME

Mrs Rosa Bernstein

(a) RESIDENCE NO.

2401 E. Chase

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

15 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

15 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

F

W

Married

5a If married, widowed, or divorced

HUSBAND (or) WIFE of

Max Bernstein

6 DATE OF BIRTH (month, day, and year)

February

7 AGE

40

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Aaron Bernstein

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Max Bernstein 2401 E Chase St

15

Filed

C. HAMPTON JONES M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 3 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1928, to April 3, 1928

that I last saw him alive on

April 3, 1928

and that death occurred, on the date stated above, at

8.40 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis  
Rheumatic Cardio-Vascular Dis.

CONTRIBUTORY (Secondary)

(duration) yrs. 5 mos. ds.

Bronchopneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Physical signs

(Signed)

Milton Sherry, M. D.

, 19 (Address)

Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL  
Northman Circle Cem

DATE OF BURIAL

4/4 1928

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 5th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32463

## CERTIFICATE OF DEATH.

49 E 32463

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5008 Denmore ave ST. 7-56 WARD)

2-FULL NAME Benjeman Fox

(a) RESIDENCE NO. 5008 Denmore ave ST. 7-56 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of or WIFE of Hilda Fox

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years 67 Months — Days — If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ben Hart (Address) 5008 Denmore ave

15 Filed WILLIAMSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 19 28

17 I HEREBY CERTIFY, That I attended deceased from March 28, 19 28, to April 3, 19 28, that I last saw him alive on April 3, 19 28, and that death occurred, on the date stated above, at 12:26 P m.

The CAUSE OF DEATH\* was as follows:  
Carcinoma of lung

(duration) 1 yrs. mos. ds.  
CONTRIBUTORY (Secondary) Hemorrhage, exhaustion  
(duration) — yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination  
(Signed) Joseph J. Jones, M. D.

4/4, 1928 (Address) 5201 Garrison Blvd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Heaven Burial Home

4/4/28

20 UNDERTAKER

ADDRESS

Jack Lewis 1429 E. Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32464

## CERTIFICATE OF DEATH.

E 32464

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4-25 ST. WARD)2. FULL NAME Edward Osentin

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 222 W. Pearl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 2 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) ?5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?7 AGE Years 35 Months 0 Days 0 If LESS than 1 day, 0 hrs. 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Samuel Osentin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Delaware12 MAIDEN NAME OF MOTHER Samuel ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14

Informant (Address) Records

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 23, 1928, to Mar. 31, 1928that I last saw him alive on Mar. 31, 1928and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH\* was as follows:

Myocarditis chronic acute  
arteriosclerosis  
Hypertension(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? yesWhat test confirmed diagnosis? General & Sub(Signed) C. Stulen Boyd, M. D., 19 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Laurel Cemetery

DATE OF BURIAL

April 4, 1928

20 UNDERTAKER

Mrs. Kate R. WilliamsADDRESS 327N. Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

R 4 Filed 1928 C. H. HAYES, M. D. Registrar

E 32465 HEALTH DEPARTMENT—CITY OF BALTIMORE *oe* 32465

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital 77-30* ST. *74* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Eddie Dunlop*(a) RESIDENCE NO. *579 Bann St* ST. *74* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Beatrice Dunlop*6 DATE OF BIRTH (month, day, and year) *July 3 1895*7 AGE Years *28* Month *9* Day *0* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Lancaster* (State or country) *S. C.*10 NAME OF FATHER *Wm Dunlop*11 BIRTHPLACE OF FATHER (city or town) *Lancaster* (State or country) *S. C.*12 MAIDEN NAME OF MOTHER *Elizabeth McLeod*13 BIRTHPLACE OF MOTHER (city or town) *South Carolina* (State or country)14 Informant *James Dunlop* (Address) *523 Bann St*15 Filed *PR 4 - 1928* *C. HARTSON JONES, M. D.* 19 *1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/3/28* 1917 I HEREBY CERTIFY, That I attended deceased from *3/31/28*, 19, to *4/3/28*, 19, that I last saw him alive on *4/3/28*, 19, and that death occurred, on the date stated above, at *3:30 A* m.

The CAUSE OF DEATH\* was as follows:

*apoplexy*(duration) yrs. mos. *3* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Autopsy* (Signed) *Lewis Elds Taylor*, M. D., 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR RE-  
MOVAL *Lancaster S. C.*

DATE OF BURIAL

*4/4 28* 1920 UNDERTAKER *Mrs.*ADDRESS *522**Hotie A. Williams**H. Schroeder*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.



E32466, HEALTH DEPARTMENT—CITY OF BALTIMORE

E32466

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Bayard ST. 21-28 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

Rose Cecilia Reynolds

## (a) RESIDENCE NO.

1107 Bayard

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced, (write the word) Widowed
-----------------	--------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of George H. Reynolds

6 DATE OF BIRTH (month, day, and year) Mar 8 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	10	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Baltimore Maryland

## 10 NAME OF FATHER

Thomas Wigner

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Washington DC

## 12 MAIDEN NAME OF MOTHER

Rose Wigner

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

## 14

Informant Mrs. John H. Guice

(Address) 1107 Bayard St.

## 15

APR 4 1928 HAYDON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2-1928

## 17

I HEREBY CERTIFY That I attended deceased from Feb 5th 1928 to Apr 1st 1928

that I last saw him alive on March 31, 1928

and that death occurred, on the date stated above, at 11:15 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of ileum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Anemia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Usual tests -

(Signed) St. Croix M. D.

4-3-1928 (Address) 2202 W North St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cemetery

## 20 UNDERTAKER

Mary W. Wiedefeld

## DATE OF BURIAL

April 4, 1928

## ADDRESS

501 E 22nd St

OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32467

## CERTIFICATE OF DEATH.

90 E 32467

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 14-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Emory Jones(a) RESIDENCE No. 508 Bleu ST. 14-54 WARD 14-54

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) ?5a If married, widowed, or divorced HUSBAND of or WIFE of ?6 DATE OF BIRTH (month, day, and year) ?7 AGE Years Months Days If LESS than 1 day, hrs. or min. 60

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER ?11 BIRTHPLACE OF FATHER (city or town) (State or country) ?12 MAIDEN NAME OF MOTHER ?13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14

Informant (Address) Records

15

Filed C. H. HARRIS Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 27, 1928 to Apr. 2, 1928.that I last saw him live on Apr. 2, 1928.and that death occurred, on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH\* was as follows:

Vincent's angina  
gastro-intestinal Vincent's

(duration) yrs. 1 mos. ds.

CONTRIBUTORY myocarditis, chronic

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? General & Lab(Signed) C. H. Harris M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Ball Creek, Calvert & Md4/5 1928

20 UNDERTAKER

ADDRESS

Thomas E. Kelem1302 Preston St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



212697  
E 32469

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 84 E 32469

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Eddie May Baum

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Kitty Hawk, D.C.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Female WhiteChild

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 3/24

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4 yrs28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Hom.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

North Carolina

10 NAME OF FATHER

Edmund Baum

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

N. Carolina

12 MAIDEN NAME OF MOTHER

Edna Tiller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

North Carolina

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

W. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 3 1928

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1928, to April 3, 1928.that I last saw her alive on April 3, 1928, and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH\* was as follows:

Brain Tumor - cerebellum  
glioma - benign(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

HomeDid an operation precede death? Yes Date of 4/3/28Was there an autopsy? Yes - 2

What test confirmed diagnosis?

(Signed) R. Pope Smith, M. D.

4/3 1928 (Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

William C. Smith  
501 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32470

## CERTIFICATE OF DEATH.

129 E 32470

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2814 7/ Lafayette Ave ST. 16-68 WARD)2-FULL NAME Charles R. Shipley(a) RESIDENCE NO. 2814 7/ Lafayette Ave ST. 16-68 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE W5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnus Shipley6 DATE OF BIRTH (month, day, and year) May 3, 1853

7 AGE

Years 74Months 7Days 29

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman, Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md10 NAME OF FATHER James Shipley11 BIRTHPLACE OF FATHER (city or town) (State or country) Md12 MAIDEN NAME OF MOTHER Mary Burke13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14

Informant (Address) Agnus Shipley

15

Filed

1928 HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1928, to April 2, 1928.that I last saw him alive on April 2, 1928.and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 14

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical findings(Signed) Harold E. Zeph, M. D.4/3/1928 (Address) 3048 N. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDER-REAKER

ADDRESS

W. M. Cook4/4 1928502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32471

## CERTIFICATE OF DEATH.

129 E 32471

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3412 Holmes Ave ST. 3-54 WARD)

2-FULL NAME Ella M. Petts

(a) RESIDENCE NO. 3412 Holmes Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. dt. How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND or (or) WIFE of Elias Petts

6 DATE OF BIRTH (month, day, and year) April 8<sup>th</sup> 1871

7 AGE 56 Years Months Days If LESS than 1 day, hrs. or min. 57 11 25

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER John Tricker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary F. Hobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr Petts (Address) 3412 Holmes Ave

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3<sup>rd</sup> 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar. 12, 1928, to Apr. 3, 1928.

that I last saw him alive on Apr. 3, 1928.

and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency  
3-4 weeks

(duration) yrs. mos. ds.

CONTRIBUTORY Bright's Disease - arterial (Secondary) Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? microscopic

(Signed) Henry E. Wilson M. D.

, 19 (Address) 13 W. Biddle

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lind Ridge Cemetery April 5, 1928

UNDERTAKER Henry Jenkins & Sons ADDRESS Chesapeake

APR 4 - 1928 HAMPSON JONES, M. D. Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32472

## CERTIFICATE OF DEATH

REGISTERED NO.

E 32472

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1626 N. Bradford St., 8-16 Ward)2-FULL NAME Margaret Louis Brader

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1626 N. Bradford St. 8-16 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 5 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 1 yr. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28 19257 AGE Years 3 Months — Days 5 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) MD10 NAME OF FATHER Nicholas J. Brader11 BIRTHPLACE OF FATHER (City or town) Baltimore (State or country) MD12 MAIDEN NAME OF MOTHER Emma D. Hoffman13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) MD14 Informant Mr. Nicholas J. Brader (Address) 1626 N. Bradford15 Filed APR 4 - 1928 G. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 192817 I HEREBY CERTIFY, That I attended deceased from April 28 to April 3 1928 that I last saw him alive on April 2 1928 and that death occurred on the date stated above, at 3 a. m.

The CAUSE OF DEATH\* was as follows:

InfancyCONTRIBUTORY (duration) 2 yrs. 0 mos. 2 da. (Secondary) Infancy18 Where was disease contracted (duration) 1 yrs. 0 mos. 1 da.If not at place of death? InfancyDid an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Infancy(Signed) J. H. Jones, M. D.19 Address 1626 N. Bradford

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial 10-2820 UNDERTAKER Henry Hark Son ADDRESS 1801 E. Engle

B—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 4 - 1928

E 32473

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32473

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1140 Kirk 17-24 Ward)2-FULL NAME Bruce Burgess(a) RESIDENCE NO. 1140 Kirk St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Leol 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) May 30 - 19007 AGE Years 27 Months 10 Days 2 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Richmond(State or country) va10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (city or town) va

(State or country)

12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) va

(State or country)

14 Informant Ruby Deag  
(Address) 1140 Kirk15 Filed G. HARDYAN JONES, M.D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1 - 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an \_\_\_\_\_ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said \_\_\_\_\_ (Inquest, autopsy or inquiry.) and that said deceased came to \_\_\_\_\_ death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 9 ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. P. Link M. D.(Address) North Ave & Lehigh

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 REMOVAL \_\_\_\_\_, CRIMINAL OR \_\_\_\_\_ Date of Burial 4-3-28ADDRESS 916

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



E 32474

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32474

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2826 Huntington Ave 12-51 RD)

## 2-FULL NAME

Baby Colburn

## (a) RESIDENCE No.

2826 Huntington Ave

(Usual place of abode)

## WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

W.

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

April 2, 1928

## 7 AGE

Years

Months

Days

If LESS than 1 day, 5 hrs. or 15 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Edw R. Colburn

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Helen E. Sullivan

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

## 14

Informant (Address)

## 15

1928

JOHN HOPKINS HOSPITAL REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 3 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

4/2 1928, to 4/3 1928

that I last saw him alive on 4/2 1928

and that death occurred, on the date stated above, at 291 m.

The CAUSE OF DEATH\* was as follows:

6 Mo. Premature Birth

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. W. H. M. D.

4/3 1928 (Address) 2020 N. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

Commissioner Health

APR 4 - 1928

E 32475

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32475

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1617 N. Monroe*)2-FULL NAME *Ann M. Bowen*(a) RESIDENCE NO. *1617 N. Monroe*

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. mos. ds.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

*16-22* WARD

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 3, 1847*

7 AGE

Years *80*Months *11*Day *0*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Penna*10 NAME OF FATHER *Sam H. Bowen*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Penna*12 MAIDEN NAME OF MOTHER *Lucy A. Van Orsdie*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Penna*

14

Informant (Address) *Mr. J. E. Perrine 1617 N. Monroe St*

15

1628

G. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 5, 1928* to *April 3, 1928*that I last saw her alive on *April 2, 1928*and that death occurred, on the date stated above, at *5 a-m*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage. Had several recurrences in the last (duration) 4 yrs. mos. ds.*CONTRIBUTORY *Arterio-Sclerosis* (Secondary) *about* (duration) *6* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. H. Drivall*

M. D.

(Address) *1817 N. Fulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Gettysburg, Pa*

20 UNDERTAKER

*J. J. Jones, Inc*

DATE OF BURIAL

*Apr 5, 1928*

ADDRESS

*2 Paton*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

R 4

32476

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32476

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 17-24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John Green(a) RESIDENCE No. 827 W. Biddle St.

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds.

## WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

?5a If married, widowed, or divorced HUSBAND of or WIFE of ?6 DATE OF BIRTH (month, day, and year) ?

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?10 NAME OF FATHER ?11 BIRTHPLACE OF FATHER (city or town) (State or country) ?12 MAIDEN NAME OF MOTHER ?13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

## 14

Informant (Address) Baltimore City Hospital

## 15

File

G. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/1928

17

I HEREBY CERTIFY, That I attended deceased from Mar. 30, 1928 to Mar 30, 1928.that I last saw him on Mar 30, 1928 and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH\* was as follows:

Subacute pneumonia

(duration) yrs. mos. ? ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date of ?Was there an autopsy? noWhat test confirmed diagnosis? General & Sub(Signed) C. J. Jones, M. D., M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

UNIVERSITY OF MARYLAND

ADDRESS

1928

APR 4

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement on back of certificates. TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32477

E 32477

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *713 Woodbourne ave* ST. *2748* (WARD))2-FULL NAME *Anna L. Hicks*(a) RESIDENCE No. *713 Woodbourne ave*  
(Usual place of abode)Length of residence in city or town where death occurred *30* yrs. mos.ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If ~~married, widowed, or divorced~~  
HUSBAND of  
(or) WIFE of *Thomas Hicks*6 DATE OF BIRTH (month, day, and year) *Aug 19<sup>th</sup> 1868*7 AGE Years *59* Months *7* Days *16* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Rocks Balto County Md.*  
(State or country)10 NAME OF FATHER *James England*11 BIRTHPLACE OF FATHER (city or town) *Rocks*  
(State or country) *Harford County Md.*12 MAIDEN NAME OF MOTHER *H. R. Holland*13 BIRTHPLACE OF MOTHER (city or town) *Rocks*  
(State or country) *Harford County Md.*14 Informant *Marion Hicks*  
(Address) *715 Woodbourne Ave*15 Filed *1520* C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3 1928*17 I HEREBY CERTIFY, That I attended deceased from *March 27, 1928* to *April 3, 1928*,  
that I last saw him alive on *April 3, 1928*,  
and that death occurred, on the date stated above, at *5<sup>20</sup> A. m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma left breast*(duration) yrs. *9* mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *Yes* Date of *August 1927*Was there an autopsy? *No*What test confirmed diagnosis? *Physical symptoms*(Signed) *A. F. Robinson*, M. D.4/3, 1928 (Address) *836 Park Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Green Ridge Cemetery April 5 1928*

20 UNDERTAKER

ADDRESS

*John Robinson 1325 N. Caroline St.*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32478

## CERTIFICATE OF DEATH

REGISTERED NO.

10-001  
E 32478

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Sydenham Hospital* - 20)2-FULL NAME *George Tunstall, Jr.*(a) RESIDENCE NO. *1926 Pennsylvania Ave*

(Usual place of abode)

Ward

Length of residence in city or town where death occurred

*Life*

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Black**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Nov. 23, 1922*

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.

*5**4**11**10*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

*Baltimore*

(State or country)

*Maryland*

10 NAME OF FATHER

*George Tunstall*

11 BIRTHPLACE OF FATHER (City or town)

*Race*

(State or country)

*Ind.*

12 MAIDEN NAME OF MOTHER

*Catherine Hainwright*

13 BIRTHPLACE OF MOTHER (city or town)

*Barbados*

(State or country)

*West Indies*

14

Informant

*Mr. Cath. Tunstall*

(Address)

*1926 Pennsylvania Ave.*

15

*1928C. HAMPTON JONES, M.D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*April 3, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 24, 1928, to April 3, 1928.*that I last saw him alive on *April 3, 1928.*and that death occurred, on the date stated above, at *11:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria - Laryngeal, Pharyngeal & Tonsillar*(duration) \_\_\_\_ yrs. \_\_\_\_ mos. *45* da.

CONTRIBUTORY (Secondary)

*Acute Toxic Myocarditis*(duration) \_\_\_\_ yrs. \_\_\_\_ mos. *?* da.

18 Where was disease contracted

If not at place of death? *At home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Bacteriological*(Signed) *J. L. Kavin*, M. D.4-4-1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Mt. Auburn Cemetery 4/5 1928*

20 UNDERTAKER

ADDRESS

*Thomas E. Nelson Pierstown*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 32479

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

St Agnes Hospital 12-19 ST. WARD)

## 2. FULL NAME

Mr Harry Darden

(a) RESIDENCE NO.

209 E Mt Royal Ave ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Stella

6 DATE OF BIRTH (month, day, and year)

Aug 30 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3 5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Hotel Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Southern Hotel

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Walter Darden

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Fannie Vanable

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Mrs Stella Darden 209 E. Mt Royal Ave

15

R 4 - 1928 C. HAMPSON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-4 1928

17

I HEREBY CERTIFY, That I attended deceased from 3-28, 1928, to 4-4, 1928.

that I last saw him alive on

4-4

1928

and that death occurred, on the date stated above, at

12:10 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Autopsy by Dr. J. Van Schuy M.D. St. Agnes Hospital

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Greenboro NC

4/4 1928

20 UNDERTAKER

William Cook

ADDRESS 502 E North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32480

## CERTIFICATE OF DEATH.

E 32480

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1041 N. Mount 16-22 Ward)2-FULL NAME Abraham Abrams(a) RESIDENCE NO. 1041 N. Mount St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred none mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MalecolSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 17 - 1926

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

1416

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore10 NAME OF FATHER Joe Abrams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Calvert12 MAIDEN NAME OF MOTHER Elizabeth Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Calvert

14

Informant (Address)

Elizabeth Abrams  
1041 N. MountC. HAMPTON JONES, M. D.

15 Filed

1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 3 1928

17

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed)

F. B. Link

(Coroner)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death:

Former or usual residence:

19 PLACE OF BURIAL CREMATION OR REMOVAL Date of Burial

St. Ambrose Apr 5 1928

20 UNDERTAKER

ADDRESS

Virginia R. Brooks 14637 Ave

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 32481

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32481

## 1. PLACE OF DEATH

CITY OF BALTIMORE

No. 2802 St Paul

ST. 12 WARD

## 2. FULL NAME

Caroline Hellweg

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2802 St Paul

ST. 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

77 yrs. 3 mos. 1

How long in U. S., if of foreign birth? 77 yrs. 3 mos. 1

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White Divorced

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of Rudolph Dehl de Hattersheim

6 DATE OF BIRTH (month, day, and year)

Jan 2 / 1851

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

August Hellweg

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Lara Greener

13 BIRTHPLACE OF MOTHER (city or town)

Saxony-Germany

(State or country)

14

Informant (Address)

Mrs Henry M. Laithel (clerk) 2802 St Paul St. City.

15

FILED

1928

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 3

1928

17

HEREBY CERTIFY, That I attended deceased from

Jan 13, 1928, to Apr. 3, 1928.

that I last saw him alive on Apr. 3, 1928.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. White M. D.

4, 1928 (Address)

2800 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park Cemetery Apr 4, 1928  
Stewart Monro Balto.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32482

## CERTIFICATE OF DEATH.

E 32482

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1430 Argyle Ave St. 14 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1430 Argyle Ave St. 14 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m

4 Color or Race

col

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 10, 1927

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

10

25 24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md

## 10 NAME OF FATHER

Rayner Sanders

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md

## 12 MAIDEN NAME OF MOTHER

Kellum Dunsell

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md

14

Informant  
(Address)Rayner Sanders  
1430 Argyle Ave

C. HAMPSON JONES, M. D.

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 31, 19 28, to Apr 4, 19 28,

that I last saw him alive on Apr 4, 19 28,

and that death occurred, on the date stated above, at 6 00 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY

Measles

(Secondary)

(duration) yrs. mos. 12 ds.

18 Where was disease contracted

If not at place of death

Place of death

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

J. H. Jones, M. D.  
2329. Greenfield\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

St Peter Cemetery

Apr 5 1928

20 UNDERTAKER

ADDRESS

Wm Cook

5028  
North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 4 - 1928

E 32483

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 32483

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 14-21 WARD)2-FULL NAME James Lafferman (Luffman)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 411 Calhoun st.

(Usual place of abode)

ST. Unknown WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19167 AGE Years 12 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER John Luffman11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Willa Speede13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies14 Informant Hospital Records (Address)15 Filed APR 5 - 1928 19 HAMMON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 192817 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 19 28, to April 2, 19 28,that I last saw him alive on April 2, 19 28,and that death occurred, on the date stated above, at 3.25 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis  
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy  
(Signed) W. J. Jones, M. D.4-2-28 (Address) Baltimore City Hospitals.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Not knownMar 5 1928

20 UNDERTAKER

ADDRESS 1027John H. ToadmanHand Hill

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32485

CERTIFICATE OF DEATH

16-002 E 32485

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 0 ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Child

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

August 29, 1926

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.

67 0 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Child

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

Mo.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Harry J. Bozard

Frederick  
New Jersey

Sophia Lingby

Dayton  
Penn.

14

Informant  
(Address)

Hospital Records

15 Filed

19

HARRISON JONES, M.

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 3, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 25, 1928, to April 3, 1928.

that I last saw him alive on April 3, 1928.

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH\* was as follows:

Calculus

(duration)

yrs.

mos.

9 ds.

CONTRIBUTORY  
(Secondary)

Pulmonary edema

about one hour

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

2939 W. Lawrence St

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

M. D.

(Address)

Mad General Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Western Cemetery

April 3 1928

20 UNDERTAKER

Robert Brookseon

ADDRESS  
Gathoun  
Hollins



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129E 32486

E 32486

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *4-7* Ward)2-FULL NAME *LUDWIG Beck*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *160 N. May St*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *32* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>male</i>	4 Color or Race <i>White</i>	5 Single, Married, Widowed, or Divorced, (write the word) <i>Single</i>
----------------------	---------------------------------	--

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE	Years	Months	Days	IF LESS than 1 day _____ hrs. or _____ min..
	<i>48</i>	<i>-</i>		

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Baker*

## 9 BIRTHPLACE (city or town)

(State or country)

*Germany*

## 10 NAME OF FATHER

*John Beck*

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Germany*

## 12 MAIDEN NAME OF MOTHER

*Unknown*

## 13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

*Unknown*

## 14

Informant  
(Address)*George M. Beck  
3608 Harlem Ave*

15 Filed \_\_\_\_\_, 19 \_\_\_\_\_

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/4/28* 19 \_\_\_\_\_

## 17

I HEREBY CERTIFY, That I attended deceased from

*1/20/28*, 19 \_\_\_\_\_, to *4/4/28*, 19 \_\_\_\_\_,that I last saw him alive on *4/4/28*, 19 \_\_\_\_\_,and that death occurred, on the date stated above, at *6:30* a.m.

The CAUSE OF DEATH\* was as follows:

*Hypertensive Cardiovascular Disease*(duration) *17* yrs. mos. ds.CONTRIBUTORY  
(Secondary)*Chronic Nephritis*(duration) *7* yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) *J. E. Winstead*, M. D., 19 \_\_\_\_\_ (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*London Park**Apr 7 1928*

## 20 UNDERTAKER

ADDRESS

*Mr. Mrs. John W. Deifel & Son 801 N. Fayette*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 32487

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32487

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Wash. Blvd. ST. 21-29 WA. D)

## 2-FULL NAME

Emma Pascal

(a) RESIDENCE NO. 1215 Wash. Blvd. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? 53 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Marion V. Pascal

6 DATE OF BIRTH (month, day, and year)

Jan 1, 1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59

3

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

010

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Marion V. Pascal 1215 Wash. Blvd.

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4, 1928

17

I HEREBY CERTIFY, That I attended deceased from 4:00 Jan 1928 to 4:00 Jan 1928, that I last saw her alive on 3rd Nov 1928

and that death occurred, on the date stated above, at 12.45 a. m.

The CAUSE OF DEATH\* was as follows:

Gastric carcinoma

(duration)

yrs.

6 mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Gastric analysis &amp; diag.

(Signed) H. H. H. M. D.

4/4, 1928 (Address) 11 W. 4th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

Apr. 7, 1928

UNDERTAKER

Mrs. John R. Puffer - Son

ADDRESS

811 Fayette

APR 5 - 1928

H. H. H. JONES, M. D. Registrar

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—3500 Bks.

E 32488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-091 E 32488

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2800 Harlen Ave.

ST. 16-68

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emelie Kaiss.

(a) RESIDENCE NO.

2800 Harlen Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

62 yrs 7 mos 15 ds

ST.

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White.

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, with whom known (or) WIFE of

George Kaiss.

6 DATE OF BIRTH (month, day, and year) Aug. 19, 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

7

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Theowald Deppenbrock

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany.

12 MAIDEN NAME OF MOTHER Marie Link.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany.

14 Informant George Kaiss. (husband) (Address) 2800 Harlen Ave.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1928 to April 3, 1928.

that I last saw her alive on April 3, 1928.

and that death occurred, on the date stated above, at 5 1/2 p. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY Acute dilatation of the Heart. (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto W. Reinhardt, M. D.

4/4, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

DATE OF BURIAL

Apr 6, 1928

20 UNDERTAKER

Mr. Mrs. John W. Gensel & Son 801 W. Fayette





E 32490

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32490

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 3-5-1928, to 4-2-1928.

that I last saw him live on 4-1-1928

and that death occurred, on the date stated above, at 9:15 A. M.

The CAUSE OF DEATH\* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Pathological &amp; Clinical findings

(Signed) Mary H. H. Smith, M.D. 4/2/28 Address: Baltimore City Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 3 - 1928

Registrar

E 32491 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32491

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore Capital 16-27*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Ida M. Colley*(a) RESIDENCE NO. *2000 Edmondson Ave*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Widowed*5a If married, widowed, divorced, ~~husband~~ or ~~wife~~ of *James A. Colley*6 DATE OF BIRTH (month, day, and year) *March 29-1856*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*72-**0**6**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto*10 NAME OF FATHER *Joseph Huntley*11 BIRTHPLACE OF FATHER (city or town) (State or country) *md.*12 MAIDEN NAME OF MOTHER *Virginia Miles*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *md.*14 Informant *James E. Colley*  
(Address) *2000 Edmondson Ave*15 Filed *1928* *C. H. JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-4-1928*

17

I HEREBY CERTIFY, That I attended deceased from *4-2-1928*, to *4-4-1928*that I last saw *h* alive on *4-4-1928*and that death occurred, on the date stated above, at *2:40 a* m.

The CAUSE OF DEATH\* was as follows:

*Voluntary ascending aortic and descending aorta - Atherosclerotic Obstruction (chronic)*(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *yes* Date of *4-2-28*Was there an autopsy? *no*What test confirmed diagnosis? *Operation*(Signed) *Blum*

, 19

(Address) *Baltimore Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Western Cemetery**April 6 1928*

20 UNDERTAKER

ADDRESS

*Charles J. Schwab* *505 N. Monroe St.*

B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A STATEMENT OF FACTS. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32492

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St. Agnes Hospital*

CITY OF BALTIMORE: (No. ....)

2-FULL NAME *Mrs. Johanna High*

(a) RESIDENCE NO. *2225 Christian St.*  
(Usual place of abode)

Length of residence in city or town where death occurred *about* . mos.

ST. *W-69* WARD

REGISTERED NO. ....  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. .... WARD ....  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 7/1887*

7 AGE *40* Years Months Days *1 26* If LESS than 1 day, hrs. or min. *25*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Seamstress*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)

10 NAME OF FATHER *George H. High*

11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)

12 MAIDEN NAME OF MOTHER *Louisa Schmiedel*

13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)

14 Informant *Son - Edward High*  
(Address) *2225 Christian St.*

15 Filed *19* *W. JONES, M. D.* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-2-1928*

17 I HEREBY CERTIFY, That I attended deceased from *2-20-1928* to *4-2-1928*, that I last saw her alive on *4-2-1928* and that death occurred, on the date stated above, at *6 10 P M*. The CAUSE OF DEATH\* was as follows:

*Cardio-Vascular-Nervous Disease (non-symptomatic)*

(duration) *4* yrs. mos. ds. CONTRIBUTORY (Secondary) *Cerebral embolism*  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

*Augustine J. von Schatz, M. D.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT *Western Cemetery* DATE OF BURIAL *Apr. 5 1928*

20 UNDERTAKER *George L. Schwab* ADDRESS *2101 E. Pratt St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Bks.

E 32493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 E 32493

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2147 Homewood Ave

ST., WARD)

2-FULL NAME Rose Marie Hunt

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2147 Homewood Ave  
(Usual place of abode)

ST., WARD Resident

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 4 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year) April 1- 1928

7 AGE Years Months Days If LESS than 1 day, hrs or min. 0 0 4 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER George W. Hunt

11 BIRTHPLACE OF FATHER (city or town) Riegelville (State or country) N.J.

12 MAIDEN NAME OF MOTHER Rose Golnik

13 BIRTHPLACE OF MOTHER (city or town) Astoria (State or country) Ore.

14 Informant Mr Geo. W. Hunt (Father) (Address) 2147 Homewood Ave

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1928

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 4, 1928, that I last saw her alive on April 4, 1928, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH\* was as follows:

Septic Neonatorum (Septic) Measles in house when infant was born + mother in poor health

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

44, 1928. (Address) 424 E. North Av.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Riegelville, N.J.

April 6 1928

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32494

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

### 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 19-27 Ward)

2-FULL NAME Nellie A. Schramm

(a) RESIDENCE NO. 1423 Edmondson Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles J. Schramm

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1879

7 AGE Years 48 Months 7 Days 19 IF LESS than 1 day.....hrs. or.....min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

10 NAME OF FATHER John T. Gates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy M. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Charles Schramm (Address) 1423 Edmondson Ave.

15 Filed APR 5 1928 JOHN JONES, M. D. Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1928 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured Skull

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. (Signed) Regina Ziller M. D. (Coroner)

4/4 1928 Address 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Cathedral Cemetery 4/7 1928

20 UNDERTAKER Chas. J. Wane ADDRESS 1800 Royal Lane

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-00

32495

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1 Indivale Road, No. 1 ST. 1 WARD 1  
(Usual place of abode) (If none)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 19 28

17 I HEREBY CERTIFY, That I attended deceased from  
March 30, 1928, to April 4, 1928  
that I last saw him alive on April 4, 1928  
and that death occurred, on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH\* was as follows:

Ovarian Pregnancy

(duration) yrs. 2 mos 0 ds  
CONTRIBUTORY (Secondary) *Intestinal Obstruction*

18 Where was disease contracted if not at place of death? 71 Midvale Road, Poland

Did an operation precede death? Yes Date of Mar. 31, 1925

Was there an autopsy? Yes

What test confirmed diagnosis? *Autopsy*

(Signed) J. H. Krook, M. D.  
, 19 (Address) Woman's Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

10 NAME OF FATHER *William Franklin Willard*

12 MAIDEN NAME OF MOTHER *Bessie E. Appleby*

13 BIRTHPLACE OF MOTHER (city or town) Washington  
(State or country) D.C.

14 Informant Edmond J. Prince  
(Address) 1111 1/2 Michigan Road, Detroit, Mich.

15 Filed. 1928 C. HAMMOND JONES, M.D. Registrar

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL.	DATE OF BURIAL
--	----------------

UNDERTAKER	ADDRESS
Wm O. Mitchell Sons 1905 Cedar	Plaza

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32496

## CERTIFICATE OF DEATH.

56 E 32496

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST., *get* WARD)2-FULL NAME *Respirina Cardige*(a) RESIDENCE NO. *430 S Broadway* ST., *get* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Sept. 10 1927*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Evangelos Cardiges*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Greece*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Greece*

14

Informant *Evangelos Cardiges*(Address) *h 430 S Broadway*

15

Filed

APR 5 - 1928

C. H. HANCOCK, M. D., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Apr 4 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr 2*, 1928, to *Apr 4*, 1928, that I last saw her alive on *Apr 4*, 1928,and that death occurred, on the date stated above, at *3:10 Pm*

The CAUSE OF DEATH\* was as follows:

*Mal-nutrition  
Rickets*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Lawrence Zahm*, M. D., 19 (Address) *St Josephs Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodlawn Cem. April**5 1928*

20 UNDERTAKER

ADDRESS

*John M. Weber 4012 Chester St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.





N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 32498 HEALTH DEPARTMENT—CITY OF BALTIMORE E 32498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Ramsay

ST. 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Brady

(a) RESIDENCE. NO. 1812 Ramsay St.

(Usual place of abode)

Length of residence in city or town where death occurred

Life

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) March 22-1928

7 AGE Years 7 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Wilmer Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Wilmer F. Brady 1812 Ramsay St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar 29 1928, to Apr 5 1928,

that I last saw her alive on Apr 4 1928,

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

Patent Hernia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

18 Where was disease contracted (duration) yrs. mos. ds.

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician's

(Signed) James L. Brady M. D.

4/5/28 Address 1729 Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

4/5/28 19

20 UNDERTAKER

ADDRESS

Harry W. Witzke

1531 W Lombard

APR 5 - 1928

RECORDED & INDEXED

## E 32499 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 E. Cross ST., 24-33 WARD)2. FULL NAME Martin Buchanan Gallagher(a) RESIDENCE No. 100 E. Cross

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST., WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)MaleWhiteMarried5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofLadie Gallagher

6 DATE OF BIRTH (month, day, and year)

April 9/1856

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

711128

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workRetired(b) General nature of industry,  
business, or establishment in  
which employed (or employer)Candy-maker

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore Md

10 NAME OF FATHER

Patrick Gallagher11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Baltimore Md

12 MAIDEN NAME OF MOTHER

Elizabeth Brian13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Baltimore

14

Informant  
(Address)John A Gallagher  
429 Bevan St

15

Filed

19202122232425

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 28/28, 19, to April 3/28, 19.that I last saw him alive on April 3/28, 19.and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

acute distal pharyngitisCONTRIBUTORY  
(Secondary)Hartman & Neff  
Pharyngitis  
7 days18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

John P. Denny  
123 High

M. D.

\*State the Disease Causing Death, or in death from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

New Cathedral CemeteryApr 6 1928

20 UNDERTAKER

ADDRESS

John P. Denny715 Light StN. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state  
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Hks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32500

## CERTIFICATE OF DEATH.

129 E 32500

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals ST. 11-24 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Parr

(a) RESIDENCE No. 1320 Linden ave.

(Usual place of abode)

ST. 11-24 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida F. Parr

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years 60 Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Weedon Parr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Dearing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address)

15 Filed C. HANSEN JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 19 28

17 I HEREBY CERTIFY, That I attended deceased from March 30, 19 28, to April 4, 19 28.

that I last saw him alive on April 4, 19 28.

and that death occurred, on the date stated above, at 2.40 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Myocardial

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) J. W. Madden, M. D.

(Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Warrenton Va

April 16, 1928

20 UNDERTAKER

ADDRESS

George S. Bullock & Sons 1212 N. Main St.

E 32501

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32501

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital 7-13* ST. *7-13* WARD)

## 2-FULL NAME

*George Brooks*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*1203 N. Durham* ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*male*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Catherine Brooks*

## 6 DATE OF BIRTH (month, day, and year)

*Jan 1854*

## 7 AGE

Years

Months

Days

*74**3*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*me*

## 10 NAME OF FATHER

*John Brooks*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*me*

## 12 MAIDEN NAME OF MOTHER

*Catherine*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*German*

## 14

Informant (Address)

*George Brooks 1203 N. Durham St.*

## 15

Filed

19

*C. H. HARRIS, M.D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *11-4* 19 *28*

## 17

I HEREBY CERTIFY, That I attended deceased from

*3-21-1928* to *11-4-1928*that I last saw him alive on *11-4-1928*and that death occurred, on the date stated above, at *2:30* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial nephritis Chronic Arteriosclerosis*(duration) *subacute* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. *3* ds.

## 18 Where was disease contracted

if not at place of death? *None*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *James M. Brooks, M.D.*, 19 (Address) *Balti City Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Emanuel Lem-Land*

## DATE OF BURIAL

*Nov 6 1928*

## 20 UNDERTAKER

*Leo G. Brook*

## ADDRESS

*1723 Patt. Ph*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



E 32502

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32502

## CERTIFICATE OF DEATH.

161-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home* ST. *1562* WARD)2-FULL NAME *Baby Boy Wenchel*(a) RESIDENCE NO. *3601 Edgewood Rd*

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

yrs.

mos.

/

ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*m*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Infant*

6 DATE OF BIRTH (month, day, and year)

*Apr 4, 1928*

7 AGE

Years

Months

Days

If LESS than  
1 day, 15 hrs.  
or 4 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore  
md*

10 NAME OF FATHER

*John Frederick Wenchel*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Baltimore  
md*

12 MAIDEN NAME OF MOTHER

*Martha Hertel*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore  
md*

14

Informant  
(Address)*John Frederick Wenchel  
3601 Edgewood Rd*

15

Filed

APR 5 - 1928

1928

HAMPSON JONES, M. D.

Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Apr 5, 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*April 4, 1928, to April 5, 1928.*that I last saw him alive on *Apr 5, 1928*and that death occurred, on the date stated above, at *8:10 A m.*

The CAUSE OF DEATH\* was as follows:

*Premature - Seven months -*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. Frank Hewitt* M. D.*Apr 5, 1928* (Address) *C N Y C*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*Arundel College**Apr 5, 1928*

20 UNDERTAKER

*J. Dickson Jones*



E 32504

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32504

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2100 E Balto*ST. *6-10* WARD)2-FULL NAME *Rifka Aronson*(a) RESIDENCE NO. *2100 E Balto*

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred *4* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? *4* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) \_\_\_\_\_5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year) *1869*7 AGE Years *59* Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_ *none*

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) *Russia*  
(State or country)10 NAME OF FATHER *Moses Marcus*11 BIRTHPLACE OF FATHER (city or town) *Russia*  
(State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Russia*  
(State or country)14 Informant *Max Aronson*  
(Address) *3420 - 11 St N.W.*15 *1928* *C. HAMPTON JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 4 1928*17 I HEREBY CERTIFY, That I attended deceased from *Dec 1, 1922* to *April 4, 1928*.that I last saw him alive on *April 4, 1928*and that death occurred, on the date stated above, at *4 11* m

The CAUSE OF DEATH\* was as follows:

*myocardial infarction*(duration) *2* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted  
if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) *Levitt* M. D.4/5, 1928 (Address) *1015 E. 11 St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Liberty Mt. Carmel* DATE OF BURIAL *4/6 1928*20 UNDERTAKER *Sol. L. L. L.*ADDRESS *1127 E Balto St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32506

## CERTIFICATE OF DEATH.

E 32506

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 42 E. York St.

22-30

## 2-FULL NAME

Charles Stark.

(a) RESIDENCE NO. 42 E. York St.

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male.

White.

Do not know.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Do not know.

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

St. Louis Mo.

10 NAME OF FATHER

Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Do not know.

12 MAIDEN NAME OF MOTHER

Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Do not know.

14

Informant Lester R. Nachter.

(Address)

42 E. York St.

15 Filed

C. HAMPSON JONES, M. D.

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 26, 1928

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.) find that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(Signed)

(Coroner)

3/31, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

APR 5 - 1928

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE  
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is  
very important. See instructions on back of certificate.

THE MORQUE

N. B. - Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

E 32507

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 32507

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 Garrison St. 15-61 WARD)

2-FULL NAME

Rev A Stewart Hartman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2608 Garrison Ave. St.; 15 yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

M

4-COLOR OR RACE

W

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

M

6-DATE OF BIRTH

Dec 19

(Day)

1945

(Year)

7-AGE

82

3

mos.

13

ds.

or

min.?

If LESS than

1 day, hrs.,

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Preacher

9-BIRTHPLACE

(State or country)

Pa.

10-NAME OF FATHER

Moses Hartman

11-BIRTHPLACE OF FATHER

(State or country)

Pa.

12-MAIDEN NAME OF MOTHER

Elybeth Rebert

13-BIRTHPLACE OF MOTHER

(State or country)

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rev H Hartman

(Address)

2608 Garrison

15-

C. HAMPSON JONES, M. D.

Filed

1928

191

R. W. Jones

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April

2

1948

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

Jan 24, 1948, to,

Apr 2

1948

that I saw him alive on

Apr 2

1948

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH\* was as follows:

Heart Disease

Myocardial degeneration

Similarity

(Duration)

hrs

mos.

ds.

Contributory (SECONDARY)

Similar Myocardial

(Duration)

hrs

mos.

ds.

(Signed)

C. H. Hampson

M. D.

4/3

1948

[Address]

2608 Garrison

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

hrs. mos. ds.

In the

State

hrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethesda

April 6, 1948

20-UNDERTAKER

H. W. Rounton

ADDRESS

2238 W. North

E 32508

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32508

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *206 Putapsco* St. *25-32* Ward) *90*

Registered No. ....

2-FULL NAME *Julia R. Whipple*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *206 Putapsco* St. .... Ward. ....

(Usual place of abode)

Length of residence in city or town where death occurred *14* yrs. *11* mos. *23* ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-Single *Single*  
Married, Widowed, or Divorced (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) *April 10<sup>th</sup> 1913*7-AGE *14* yrs. *11* mos. *23* ds. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *School Girl*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9-BIRTHPLACE (city or town) *Balto Md*  
(State or Country)10-NAME OF FATHER *Henry B. Whipple*11-BIRTHPLACE OF FATHER (city or town) *Balto Md*  
(State or Country)12-MAIDEN NAME OF MOTHER *Lena C. Kaline*13-BIRTHPLACE OF MOTHER (city or town) *Balto Md*  
(State or Country)14- (Informant) *Henry B. Whipple*  
(Address) *206 Putapsco St. Baltimore*15- Filed *1928* *C. HAMPTON JONES, M. D.* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *April 21<sup>st</sup> 1928*17- I HEREBY CERTIFY, That I attended deceased from *Jan* 1927 to *April 3* 1928, that I last saw her alive on *April 3* 1928, and that death occurred, on the date stated above, at *3 p.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic valvular heart disease*(Duration) *1* yrs. *3* mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted? If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Heart action*(Signed) *R. V. Glavin* M. D. *April 19 1928* (Address) *Lab. Md.*

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL *Western Cemetery* DATE OF BURIAL *April 6<sup>th</sup> 1928*20-UNDERTAKER *E. Schloman 2001* ADDRESS *1039 Hanover St*

Should be carefully supplied in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32509

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor 10-14 Ward)2-FULL NAME Dorothy Pearson(a) RESIDENCE NO. Preston + Volney St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) 19337 AGE Years 25 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) Maryland10 NAME OF FATHER Matthew Beckton

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Behch Beckton

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

14 Informant Little Sisters of the Poor (Address) Preston + Volney St.15 Filed 1928 19 \_\_\_\_\_ Registrar W. H. Jones, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 19 28

17 \_\_\_\_\_

I HEREBY CERTIFY, That I attended deceased from 4/1 28 to 4/4 19 28, that I last saw him alive on 4/3 19 28, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

Senility (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Dr. Bernard Weiss, M. D. 4/4 19 28 (Address) 914 E. Biddle St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial April 6 19 2820 UNDERTAKER Holy Cross-Brooklyn Md. ADDRESS 914 Greenwich Ave

E. 32509—WRITE FULL NAME OF DECEASED IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32510

## CERTIFICATE OF DEATH.

1928 E 32510

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3409 Morris Ave St. 12-59 Ward)2-FULL NAME Thomas R. Stewart(a) RESIDENCE NO. 3409 Morris Ave St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color of Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married6 If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of Sabelle Stewart7 DATE OF BIRTH (month, day, and year) May 3-18937 AGE Years 34 Months 11 Days - IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. A. D.

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) West Virginia

(State or country)

10 NAME OF FATHER Thomas Stewart11 BIRTHPLACE OF FATHER (city or town) Chillicothe, Ind

(State or country)

12 MAIDEN NAME OF MOTHER Ann E. Healy13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md

(State or country)

14 Informant Thomas R. Stewart  
(Address) 1937 N. Duane St15 Filed C. H. HAMPSON, JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and that said deceased came to this death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Shot wound through heart (Homicide)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

(Signed) Joseph Morrissey \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Coroner) \_\_\_\_\_ M. D.

(Address) 3632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the \_\_\_\_\_ State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial April 6-192820 UNDERTAKER F. B. Thepfer, 1850 N. Duane St. ADDRESS \_\_\_\_\_

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

E 32511

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32511

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 S Durham St. ST. 2-4 WARD)2-FULL NAME Zuzana Sosnowska(a) RESIDENCE NO. 413 S Durham St. ST. 2-4 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Dec 5 18877 AGE Years 40 Months 3 Days 29 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housework

9 BIRTHPLACE (city or town) (State or country)

Poland10 NAME OF FATHER Joseph Kelbaza11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14

Informant William Sosnowski  
(Address) 413 S Durham St.

15

Filed 1928 C. HAMPTON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 26, 1928, to Apr 4, 1928.that I last saw her alive on Apr 3, 1928, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:

Cardio-Vascular-Renal Disease  
(Hypertrophy with insufficiency, Thickened vessels)  
Nephritis(duration) Small yrs. mos. ds.CONTRIBUTORY Hydrothorax, Ascites  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Chemical & histology  
(Signed) G. F. Rice, M. D.Apr 5, 1928 (Address) 24 Spring

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALHoly Rosary Cem April 7 1928

20 UNDERTAKER

ADDRESS

John M. Weber 7012 Chester St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

E 32512

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32512

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Harvey St. ST. 24-33 WARD)2-FULL NAME Catherine Schindele(a) RESIDENCE NO. 617 Harvey St. ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred life mos. \_\_\_\_\_ ds. \_\_\_\_\_ How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
(If non-resident give city or town and State)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married6 If married, widowed, or divorced husband  
(or) WIFE of August Schindele6 DATE OF BIRTH (month, day, and year) July 4, 18827 AGE Years 45 Months 9 Days 1 If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N.Y.C.  
(State or country)10 NAME OF FATHER Mr. J. Klein11 BIRTHPLACE OF FATHER (city or town) N.Y.C.  
(State or country)12 MAIDEN NAME OF MOTHER Anna Schindele13 BIRTHPLACE OF MOTHER (city or town) N.Y.C.  
(State or country)14 Informant Mr. August Schindele (Husband)  
(Address) 617 Harvey St.15 Filed 1928 19 HAMPSON JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5 192817 I HEREBY CERTIFY, That I attended deceased from 2-14, 1928, to 4-5, 1928, that I last saw her alive on 4-5, 1928and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH\* was as follows:

Myocardial Regeneration(duration) yrs. 4 mos. 4 ds.  
CONTRIBUTORY (Secondary) Myocardial Degeneration  
(duration) yrs. \_\_\_\_\_ mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? noWhat test confirmed diagnosis? Chromatogram  
(Signed) St. Charles Miller, M. D.4-5 1928 (Address) 1500 N Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Joseph's Cemetery

## DATE OF BURIAL

April 9, 28

## 20 UNDERTAKER

Henry Sander & Sons IncADDRESS BALTIMORE ST. & BROADWAY

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

E 32513

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32513

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3211 Berkshire Road

2-FULL NAME LOUIS F. STAHM

(a) RESIDENCE NO. 3211 Berkshire Road

(Usual place of abode)

Length of residence in city or town where death occurred 60

yrs.

mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Bernadine Stahm

6 DATE OF BIRTH (month, day, and year) April 7, 1856

7 AGE

Years

Months

Days

71

11

27

24

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Warehouse Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pennsylvania Railroad.

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Henry Stahm

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER Johanna Mohr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant Mrs. R.C. Bonthron (Daughter) (Address) 3211 Berkshire Road.

15 Filed 1928 C. HAMPSON JONES, M. D. Registrar

27-41

ST. WARD

ST. WARD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1928

17

I HEREBY CERTIFY, That I attended deceased from October 11, 1927, to April 4, 1928.

that I last saw him alive on April 4, 1928

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH\* was as follows:

Leukemia

(duration) yrs. 7 mos. 27 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

Caleb W. P. They, M. D.

5, 1928 (Address) 100 S. Patterson Park

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cemetery

DATE OF BURIAL

April 7, 1928

20 UNDERTAKER

Henry Sander &amp; Sons Inc.

ADDRESS BALTIMORE ST. &amp; BROADWAY



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32514

## CERTIFICATE OF DEATH.

90 E 32514

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 444 E. Cross

ST. 24-33 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Carrie L. George.

## (a) RESIDENCE NO.

444 E. Cross

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female.

4 COLOR OR RACE

White.

5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Columbus M. George.

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1898.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

29.

4,

28.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Annapolis Md.

10 NAME OF FATHER Frank Larkins.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

12 MAIDEN NAME OF MOTHER Mary F. Reese.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Annapolis, Md.

14

Informant Columbus M. George.

(Address)

112 E. Hamburg St.

15

R 5 - 1928 C. 19 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1928, to April 4, 1928

that I last saw him alive on April 4, 1928

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4/8/28

1

(Address)

1644

Hawthorne

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Howard Evans 388 Port Ave

E 32515

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32515

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4808 Haddon Ave.St. 28-64 Ward)2-FULL NAME Frank Howard Smith(a) RESIDENCE NO. 4808 Haddon Ave

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.St. 28-64 Ward

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)malewhitesingle5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov. 17-1900

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.27419

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work..... clerk(b) General nature of industry,  
business, or establishment in  
which employed (or employer)..... 009(c) Name of employer City Banking Company9 BIRTHPLACE (city or town) Baltimore(State or country) Ind.10 NAME OF FATHER William Sumnerfield Smith11 BIRTHPLACE OF FATHER (city or town) Perkhutan  
(State or country) Ind.12 MAIDEN NAME OF MOTHER Minnie Bauer13 BIRTHPLACE OF MOTHER (city or town) Pittsboro  
(State or country) Ind.

14

Informant Theresa Estelle Bremner  
(Address) 4808 Haddon Ave

15

MAY 1928 C. HAMMOND JONES, M. D.  
Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5-1928

17

I HEREBY CERTIFY, That I attended deceased from  
February 12, 1928, to April 5, 1928,  
that I last saw him alive on April 3, 1928,  
and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 1 yrs. - mos. - ds.CONTRIBUTORY none

(Secondary)

(duration) - yrs. - mos. - ds.

18 Where was disease contracted

If not at place of death! unknownDid an operation precede death? no Date of -Was there an autopsy? noWhat test confirmed diagnosis? Sputum(Signed) Christian Ireland

M. D.

4-5-1928 (Address) 2532 Edmondson Ave\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

New Cathedral Cemetery Apr. 7, 1928

20 UNDERTAKER

Edmond W. Bonklin

ADDRESS

924 E. Eagan St.

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32516

## CERTIFICATE OF DEATH.

E 32516

## 1-PLACE OF DEATH

City of BALTIMORE:

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry,

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fracture of Skull  
Cerebral Hemorrhage  
Fall from House window  
(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.  
(Signed) J. H. Jones, M. D.  
(Coroner)

4/5, 1928 (Address) 3632 Roland me

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 6 - 1928

J. H. JONES, M. D.

Registrar

J. H. Jones, M. D.

J. H. Jones, M. D.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32517

## CERTIFICATE OF DEATH

REGISTERED NO.

E 32517

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1302 W. Lafayette Ave* *496-23* Ward)2-FULL NAME *Charles Edward Hurley*(a) RESIDENCE NO. *1302 W. Lafayette Ave* Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day... hrs.  
or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

I HEREBY CERTIFY, That I attended deceased from

Mar 27, 1928, to Apr 5, 1928,

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4-8-28 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 6 - 1928

19

C. HAMMOND JONES, M. D.



E 32518

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square HospitalCITY OF BALTIMORE: (No. Culhoun & Fayette ST. 13-57 WARD2-FULL NAME Carroll Bowersox(a) RESIDENCE No. 1438 Union Ave ST.  
(Usual place of abode)Length of residence in city or town where death occurred 6 yrs. mos. ds.

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32518

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

61011

If LESS than 1 day, hrs. or min.

May 5, 1928

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Westminster Md.

10 NAME OF FATHER

Carroll Bowersox

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Helen Dingle

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Westminster Md.

14 Informant (Address)

Mr. Dingle

15

Filed

G. HAMPSHIREJONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 192817 I HEREBY CERTIFY, That I attended deceased from April 1 1928, to April 5 1928, that I last saw him alive on April 5 1928, and that death occurred, on the date stated above, at 9:25 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? HomeDid an operation precede death? No Date ofWas there an autopsy? noWhat test confirmed diagnosis? X-ray(Signed) Elizabeth B. Sherman M. D.19 (Address) Franklin Square Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

W. Marshall 3539 Fall Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32519

**CERTIFICATE OF DEATH.**

# 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1013 Monroe

2-FULL NAME. George Washington

(a) RESIDENCE. NO. 1013 Mouritz ST.  
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)  
foreign birth?                      yrs.                      mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *John*

6 DATE OF BIRTH (month, day, and year) July 27, 1850

AGE	Years	Month	Days	If LESS than 1 day, hr. or min.
7	77	8	7	

### 3 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER *Daniel Alder*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *En*

12 MAIDEN NAME OF MOTHER *Elyabeth Evans*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14 Informant Mrs Eva Harrington  
(Address)

15 Filed

C. HAMPSHIRE JONES, M.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 4* 1925

17  
I HEREBY CERTIFY, That I attended deceased from  
October 15, 1927 April 4, 1928  
that I last saw him alive on April 4, 1928  
and that death occurred, on the date stated above, at 11:30 P.M.  
The CAUSE OF DEATH

The CAUSE OF DEATH\* was as follows:  
Hypostatic Pneumonia  
(pulmonary oedema)

CONTRIBUTORY (Secondary) *Cerebral Anoxia* (duration) yrs. mo. *2* da

18 Where was disease contracted  
if not at place of death? *X*

Did an operation precede death? no Date of

Was there an autopsy? no  
What test confirmed diagnosis? Phys Exam  
(Signed) James C. Faggott, M.D.  
. 19 1015 (Address) Memphis  
\*State the Di

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

5825 North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

2-FULL NAME

William Thomas

(a) RESIDENCE NO.

2123 Myra St

(Usual place of abode)

Length of residence in city or town where death occurred

28 yrs. mos. ds.

ST. \_\_\_\_\_ WARD \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of)

Rosa

6 DATE OF BIRTH (month, day, and year)

1877

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Phil Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Elizabeth S. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Rosa

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 4 1928

17

HEREBY CERTIFY, That I attended deceased from Feb. 23, 1928, to April 4, 1928, that I last saw him alive on April 4, 1928, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia, Endocarditis, Embolism.

(duration) yrs. mos. ds.

4

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

1 1/2

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

Yes

Date of Mar 24, 1928

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy

(Signed)

By man M.D.

4-5, 1928 (Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Baltimore

DATE OF BURIAL

4/7 1928

ADDRESS

507 E. North Ave

CAUSE OF DEATH IN PARTICULARS. See instructions on back of certificates.

PR 6-1928

Filed

19

C. H. JONES, M.D.

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32521

## CERTIFICATE OF DEATH.

11-081 E 32521  
 REGISTERED NO. ....  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Wilhelm St. ST. 70-28 WARD)

2-FULL NAME Ellsworth Hill Taylor

(a) RESIDENCE NO. 1907 Wilhelm St. ST. WARD  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
 (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed,  
 or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 8, 1928

7 AGE Years Months Days If LESS than  
 1 day. hrs. or min.  
 3 26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
 particular kind of work

(b) General nature of industry,  
 business, or establishment in  
 which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town,  
 State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town,  
 State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town,  
 State or country)

14

Informant  
 (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
 April 2nd, 1928, to April 4th, 1928,  
 that I last saw him alive on April 4th, 1928,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Influenza 6 Days  
 Pneumonia (bronchial)

(duration) yrs. mos. ds.

CONTRIBUTORY Cardiac Exhaustion  
 (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
 if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *E. H. Revolutum* M.D.

, 19 (Address) 24 N. Fulton Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
 MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



32522

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sp. BALTO. GEN. HOSPITAL 24-34* WARD)2-FULL NAME *MRS. ANNIE MADDOX*(a) RESIDENCE NO. *1627 WEBSTER* ST., *24* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *FEMALE* 4 COLOR OR RACE *WHITE* 5 Single, Married, Widowed, or Divorced, (write the word) *MARRIED*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *JOHN JOSEPH MADDOX.*6 DATE OF BIRTH (month, day, and year) *SEPT 22, 1895.*7 AGE Years *32* Months *6* Days *11* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *HOUSEWIFE*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *HAGERSTOWN* (State or country) *MD*10 NAME OF FATHER *CHRISTOPHER WEST*11 BIRTHPLACE OF FATHER (city or town) *NEW YORK* (State or country) *N.Y.*12 MAIDEN NAME OF MOTHER *SALLIE JAMES*13 BIRTHPLACE OF MOTHER (city or town) *HARFORD CO* (State or country) *MD.*

14

Informant *MR. J. J. MADDOX* (Address) *1627 WEBSTER ST.*

PR 5-1928 C. HANCOCK JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 15*, 1928, to *April 3*, 1928, that I last saw her alive on *April 3*, 1928.and that death occurred, on the date stated above, at *10 55* m.

The CAUSE OF DEATH\* was as follows:

*Pregnancy - Nephritic toxemia*CONTRIBUTORY (Secondary) *Post-Partum Hemorrhage* (duration) yrs. *8* mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted *Home* if not at place of death?Did an operation precede death? *No* Date of *Apr 3*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical Signs & Symptoms* (Signed) *J. E. Peterman*, M. D., 19 (Address) *1228 S. Charles St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

*Old Klam Cemetery* *4/6 28*20 UNDERTAKER ADDRESS *Wm Book* *502 E. Pratt*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

Filed

19

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

ST.

WARD)

ST.

WARD

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 26, 1928, to Apr. 4, 1928,  
that I last saw him alive on Apr. 4, 1928;  
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Peritonitis, pneumococcal

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

3 ds.

(duration)

yrs.

mos.

11 ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death?

Yes

Date of

Apr. 3, 1928.

Was there an autopsy?

Yes

What test confirmed diagnosis?

Physical, Bacteriological  
studies

(Signed)

J. J. Berman

M. D.

Address

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Oak Lawn

UNDERTAKER

Wm. Cook

DATE OF BURIAL

4/6 1928

ADDRESS

577 E. North Ave.

CAUSE OF DEATH IN plain terms, so that the layman can understand. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32524

## CERTIFICATE OF DEATH.

X 129 ✓ E 32524

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)2-FULL NAME Lillian Davis (Davies)(a) RESIDENCE NO. Union Bridge, Md. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 2 mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S. If of foreign birth?

yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female

White

Widowed

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

Feb 18, 1892

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

36

1 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

At home

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant Hospital Record

(Address)

15

Filed

PR 5 - 1928

G. HANCOCK JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year)

192

April 5, 1928

17

I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-topsy or inquiry.) and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY Cerebral Hemorrhage  
(Secondary)

(duration) ..... yrs. .... mos. .... ds.

(Signed) Eugene J. Ellis M. D.  
(Coroner)4/5 19 28. address 2739 Eastern Ave.,\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

London Park  
7th Ave4/7 1928  
502 E. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32525

## CERTIFICATE OF DEATH.

31 E 32525

## 1. PLACE OF DEATH

CITY OF BALTIMORE: No.

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

4 yrs. mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

C

Married

5a If married, widowed, or divorced  
HUSBAND of  
or WIFE of

Rosa Thomas

6 DATE OF BIRTH (month, day, and year)

Feb. 1894

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

34

## 8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Miller Co 040

(c) Name of employer

Contractors

9 BIRTHPLACE (city or town)  
(State or country)

N. C.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)Rosa Thomas (Wife)  
519 Mosher St.

15

Spec.

APR 6 - 1928

H. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 4, 1928

17

I HEREBY CERTIFY, That I attended deceased from

3-27, 1928, to 4-2, 1928,

that I last saw him alive on 4-2, 1928,

and that death occurred, on the date stated above, at 4:45 p. m.

The CAUSE OF DEATH\* was as follows:

Acute Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Calvary

Apr. 6, 1928

20 UNDERTAKER

Mrs. A. G. Elbert

ADDRESS

1725 Washington



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32526

1-PLACE OF DEATH

Sinai Hospital

CERTIFICATE OF DEATH.

129 E 32526

CITY OF BALTIMORE: (No.

2-FULL NAME

Jacob Tabak

ST. 6-10 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2109 Fairmount Ave

(Usual place of abode)

Length of residence in city or town where death occurred

20

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

20

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Bailey Jakob

6 DATE OF BIRTH (month, day, and year)

7 AGE

56

Years

Months

Days

If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Anken

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Anken

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E. Balto

15

Filed

1928

C. HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/5 1928

17

I HEREBY CERTIFY, That I attended deceased from 3-31, 1928, to 4-5, 1928,

that I last saw him alive on 4-5, 1928,

and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH\* was as follows:

Emphysema  
Cardiac insufficiency  
Chronic nephritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4/5, 1928

(Address)

J. Schwedel

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Kehren Mosh Road

DATE OF BURIAL

4/6 1928

UNDERTAKER

Jack Lewis 1439 E. Balto

CAUSE OF DEATH IN plain terms, so that the layman can understand. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32527

E 32527  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1404 N Lexington St., 19-27 Ward)2-FULL NAME Eugenia Biles(a) RESIDENCE NO. 1404 N Lexington St. 19-27 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30, 18447 AGE Years 83 Months 6 Days 4 IF LESS than 1 day...hrs. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balt Md.10 NAME OF FATHER Eugene

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Eugene12 MAIDEN NAME OF MOTHER Eugene

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Eugene14 Informant Mr. G. C. Baker  
(Address) 1404 N Lexington St.PR 6 - 1928 G. HAMMOND JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 192817 HEREBY CERTIFY. That I attended deceased from 3/15, 1927, to 4/5, 1928, that I last saw her alive on 4/5, 1928.and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration) 3 yrs. 3 mos. 3 da.(duration) ? yrs. ? mos. ? da.

13 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of ?Was there an autopsy? NoWhat test confirmed diagnosis? Symptoms(Signed) Edwin B. Gayer, M. D.

. 19

(Address) 1115 St Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Putty Hill Md.

Date of Burial

4/7/28

20 UNDERTAKER

George J. Smith Hollis & Selmer

tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 32528

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 Edmondson Ave Ward 16)2-FULL NAME Harriet K. Freeze(a) RESIDENCE NO. 1000 Edmondson Ave Ward 16Length of residence in city or town where death occurred 9 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of Geo W. Freeze (or) WIFE of6 DATE OF BIRTH (month, day, and year) May 24 18497 AGE Years 78 Months 10 Days 7 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Federick Co Md. (State or country)10 NAME OF FATHER Johnathan Dough11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)14 Informant Wm E. Freeze (Address) 1000 Edmondson Ave

APR 6 - 1928 J. A. JONES, M. D. Registrar

74-001  
E 32528  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy (duration) Sudden ds.

## CONTRIBUTORY (Secondary)

(Signed) F. B. Lusk M. D. (Coroner) (Address) 1016 North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Shurmont Md. April 6 192820 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32529

## CERTIFICATE OF DEATH.

32529

## I-PLACE OF DEATH

CITY OF BALTIMORE

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

March 28, 1928, to April 4, 1928,

that I last saw him alive on April 4, 1928,

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

, 19 (Address) 1215 Harrison St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA

4/7/28

UNDERFATER

ADDRESS

502 E. North Ave

502 E. North Ave

APR 6 - 1928 HANCOCK JONES, M.  
Registrar

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32530

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 32530

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hospital* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *911 7 Ave*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

16 Filed..... 19

19

C. H. JONES, M.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 5 1928*17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an.  
(Inquest, autopsy or inquiry.)Inquest and from the evidence obtained by said  
Inquest, autopsy or inquiry, and that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Auto Acc.  
Fracture of Skull*CONTRIBUTORY  
(Secondary)*Shock*  
(duration) yrs. mos. ds.  
(Signed) *G. C. Radio* M. D.  
(Coroner)  
19 (Address) *1436 Bway*\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place of death.....yrs.,.....mos.,.....ds. In the  
State.....yrs.,.....mos.,.....ds.

where was disease contracted, if not at place of death.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL*Italy Redemer April 7 1928*

UNDERTAKER

ADDRESS

*Wendell Dippel 37 S. Amst*

tion should be entering supplied. Exact statement of occupation of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. very important.

E 32531

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32531

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY ST. 13-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Engineer Collins(a) RESIDENCE No. 2423 Madison ST., 13-54 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds.

ds.

How long in U. S., if of foreign birth? 10 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Collins6 DATE OF BIRTH (month, day, and year) April 5 18787 AGE 49 Years 11 Months 27 Days If LESS than 1 day, 0 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) Master(c) Name of employer 0709 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER ?11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?12 MAIDEN NAME OF MOTHER ?13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14

Informant (Address) Reginald

15

Filed

R 6 - 1928

C. FRANKSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 / 2 / 1928

17

I HEREBY CERTIFY, That I attended deceased from Sept 3, 1927, to Apr 2, 1928that I last saw him live on Apr 2, 1928and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH\* was as follows:

Demiplegia - right - cerebral hemorrhage(duration) 2 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) Demiplegia - residual (duration) 1 yrs. 0 mos. 0 ds.18 Where was disease contracted ? if not at place of death?Did an operation precede death? no Date of ?Was there an autopsy? noWhat test confirmed diagnosis? General & Sub.(Signed) C. Frankson Jones, M. D.19 (Address) ?

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL St. Lukes, AveDATE OF BURIAL 4/6/28UNDERTAKER Samuel HunsleyADDRESS ?

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32532

## CERTIFICATE OF DEATH.

129 E 32532

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 Edmondson St. 27) WARD

2-FULL NAME Lena Droscher

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

(a) RESIDENCE No. 1821 Edmondson Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a Married, widowed, or divorced HUSBAND or (as) WIFE of Adolph Droscher

6 DATE OF BIRTH (month, day, and year) Dec 28 1847

7 AGE Years 80 Months 3 Days 8 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Ella Strohmmer (Address) 1821 Edmondson Ave.

15 Filed 1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-1928

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1927 to Apr 4, 1928 that I last saw her alive on March 29, 1928 and that death occurred, on the date stated above, at 10:45 A. M.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency  
 Myocarditis  
 Chronic Aneurysm  
 Aneurysm

CONTRIBUTORY (Secondary) Ordema (General) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. 2 mos. ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical exam blood + urine chemistry (Signed) Dr. A. L. L. M. D.

19 (Address) 12 E. 2nd St., Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

London Park 4-7 1928

UNDERTAKER ADDRESS

Mrs. Chas. A. G. Rohde 2327 Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates.

PR 6-1928

E 32533

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

100-001  
E 32533

## 1-PLACE OF DEATH

City of BALTIMORE:- (No. 1017 Low 5-8 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Daisy Turner

## (a) RESIDENCE NO.

1017 Low 8

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 Color or Race

C

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Samuel Turner

## 6 DATE OF BIRTH (month, day, and year)

Nov 18 1878

## 7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min..

50 4 14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

## 10 NAME OF FATHER

W. K.

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

W. K.

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)J. K. Smith  
325 Low

## 15 Filed

C. H. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 3 1928

## 17 I HEREBY CERTIFY, That I attended deceased from

March 6 1928, to April 3 1928.

that I last saw him alive on April 3 1928.

and that death occurred, on the date stated above, at 12:40 A.M.

## The CAUSE OF DEATH\* was as follows:

Bronchopneumonia  
(Primary)  
(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. K. Smith, M. D.  
April 3 1928 (Address) 508 Low

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Asbury cemetery April 6 1928

## 20 UNDERTAKER

ADDRESS

Edward Bryan Orleans St

tion should be carefully supplied. For further information, see instructions on back of certificates.

PR 1928



E 32534

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32534

## CERTIFICATE OF DEATH.

101-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital 5-8* WARD)2-FULL NAME *Louisa Ward*(a) RESIDENCE No. *1018 Low*  
(Usual place of abode)Length of residence in city or town where death occurred *10* yrs. mos. ds.

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *negro* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*John Ward*6 DATE OF BIRTH (month, day, and year) *1888*7 AGE Years *40* Months Days If LESS than  
1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *V.a*10 NAME OF FATHER *Loston Page*11 BIRTHPLACE OF FATHER (city or town) (State or country) *V.a*12 MAIDEN NAME OF MOTHER *Susan Fields*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *V.a*14 Informant *Susan Fields*  
(Address) *no fork V.a*15 Filed *APR 5 - 1928* JAMES JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/3/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *4/3/28*, 19, to *4/3/28*, 19that I last saw him alive on *4/3/28*, 19and that death occurred, on the date stated above, at *4:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*lobar pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY *cardiac dilatation*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Lawrence Fahreny*, M. D., 19 (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Asbury cemetery*

DATE OF BURIAL

*April 6 1928*

20 UNDERTAKER

*Edward Bryan*ADDRESS *1631**Orleans St*

CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

210 695  
E 32535

129 E 32535

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. ....)

## 2. FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

JOHNS HOPKINS HOSPITAL

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

3027 Hamilton Ave.

## WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced. (write the word)

Male

White

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

None

## 6 DATE OF BIRTH (month, day, and year)

1892

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

35

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

House Painter

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Adrian Geller

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ind.

## 12 MAIDEN NAME OF MOTHER

Louise Walker

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ind.

## 14

Informant (Address)

Randy

## 15

Filed

19

C. HAYNES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 4 1928

## 17

I HEREBY CERTIFY. That I attended deceased from January 31, 1928 to April 4, 1928, that I last saw him alive on April 4, 1928,

and that death occurred, on the date stated above, at

m.

## The CAUSE OF DEATH\* was as follows:

Rheumatic Heart Disease  
Chronic Nephritis

(duration) 2 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Blood Chemistry

(Signed) E. J. M. M. D.

4.5.1928 (Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Parkwood Cemetery

April 7 1928

## UNDERTAKER

## ADDRESS

George - F. Ruth 1735 Harford Ave.

E 32536

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *18* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *1803 Aiken St.*

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. *2 1/2* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan 28 / 28*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*—**2 1/2**7*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Joseph L. Gahagan*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Sarah Barlow*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

14

Informant (Address)

*Joseph L. Gahagan - 1803 Aiken St.*

15

Filed

PR 8-1928

H. H. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 5 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 4th 1928 to April 5 1928*that I last saw him alive on *April 5 1928*and that death occurred, on the date stated above, at *3 P. m.*

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Lawrence Zahner, M. D.*, 19 (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral Cemetery**April 7 1928*

20 UNDERTAKER

ADDRESS

*George J. Rutt 935 Maryland Ave*





*Lingey*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

B 32538

E 32538

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital* St. *16-67* Ward)2-FULL NAME *John R. Lingey*(a) RESIDENCE NO. *718-Diamond* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *1 yr.* mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 Color or Race

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*5a If married, widowed, or divorced HUSBAND of *Catharine A.* (or WIFE of)

6 DATE OF BIRTH (month, day, and year)

*Nov. 17, 1863*

7 AGE

Years

Months

Days

18 *18* IF LESS than

1 day.....hrs.

or.....min.

*64**4**19*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*mechanic*

(b) General nature of industry, business, or establishment in which employed (or employer)

*tool maker*

(c) Name of employer

9 BIRTHPLACE (city or town)

*Baltimore,*

(State or country)

*md.*

10 NAME OF FATHER

*John F. Lingey*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Sarah M. Mercer*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*New York.*

14

Informant (Address)

*Mrs. Walker  
718 Diamond St.*

15

Filed

1926

C. HAMMON JONES, M. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 5* 192617 I HEREBY CERTIFY that I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)Person and from the evidence obtained by said *Inquest* and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH was as follows:

*Acco Fall  
Fracture of Skull*

CONTRIBUTORY (Secondary)

(duration) *Shock* yrs. \_\_\_\_\_ mos. *1* ds. \_\_\_\_\_(duration) *96 Blades* yrs. \_\_\_\_\_ mos. *1* ds. \_\_\_\_\_

(Coroner) M. D. \_\_\_\_\_

(Address) *143 W. Bway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ In the State yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

Where was disease contracted, if not at place of death! \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of burial

*St. Oliver Cemetery**4/7 ' 1926*

20 UNDERTAKER

ADDRESS *1420**Richard W. Meyer or Ashburton*

OF DEATH in plain terms, so that it may be properly classified. Exact statement of decedent's name, age, sex, color, race, date of birth, place of birth, date of death, place of death, cause of death, and other particulars, very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32539  
1-PLACE OF DEATHCITY OF BALTIMORE: (No. *3007 Rosehemp Ave* ST. *41* WARD)2-FULL NAME *Ella E. Bowman*(a) RESIDENCE NO. *3007 Rosehemp Ave* ST. *41* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO. *E 32539*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *41*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 4, 1855*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *72 10 1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balt Md*10 NAME OF FATHER *William Bowman*11 BIRTHPLACE OF FATHER (city or town) (State or country) *England*12 MAIDEN NAME OF MOTHER *Mary Birch*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *England*

14

Informant (Address) *Engene Bishop 3007 Rosehemp Ave*

15

Filed

PR 6 - 1928

19

G. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 5 19 28*

17

HEREBY CERTIFY, That I attended deceased from

*November 1, 19 27* to *April 5, 19 28*that I last saw h. *Ev* alive on *April 5, 19 28*and that death occurred, on the date stated above, at *2:45 P. m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Breast*  
(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No*

Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

*Clinical*  
(Signed) *Harold A. Megert* M. D.*6* 19 28 Address *1031 N. Caroline*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Baltimore*

DATE OF BURIAL

*7/7 19 28*

ADDRESS

*322 E. North Ave*

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32540

PLACE OF DEATH

City of BALTIMORE: (No. 1628 Hollins St. Ward 19-28)2-FULL NAME Bettie Marie Goben(a) RESIDENCE NO. 1628 Hollins St. Ward 19-28

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 9

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, year) Oct 8 - 19267 AGE Years 1 Months 5 Days 28 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER Ollie O. Goben11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Denver, Col.12 MAIDEN NAME OF MOTHER Olive O'Brien13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Miscran14 Informant Ollie O. Goben  
(Address) 1628 Hollins St.15 Filed..... 19 C. H. JONES, M.D.  
Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 - 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Asphyxiation - found dead in bed lying face down.

## CONTRIBUTORY (Secondary)

Signed Thos. B. Norton M. D.  
(Address) 1928 Curtis Bay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See instructions on back of certificate.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tenements, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.  
Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Date of Burial April 7 1928  
UNDERTAKER George J. Smith ADDRESS 1532 Hollins

tion should be carefully supplied. Exact statement of occupation of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

8761 - 9

E 32541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 32541

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 Clinton Ave Ward 76-2)

2-FULL NAME Wm. Shelton

(a) RESIDENCE NO. 616 Clinton Ave Ward 76-2

(Usual place of abode)  
Length of residence in city or town where death occurred 14 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race Cool 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hermuth Shelton

6 DATE OF BIRTH (month, day, and year) June 30-1877

7 AGE Years 50 Months 9 Days 6 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va. (State or country)

10 NAME OF FATHER Isiah Shelton.

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Hermuth Shelton (Address) 616 Clinton Ave

15 Filed 1008 12/11/25 J. M. Jones Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.)

that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy.

(duration) .....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary)

Apr 3 1928 10th Ave & Down (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Albans Bur 4-6-1928 716 St Louis

20 UNDERTAKER

Samuel Carter

tion should be carefully supplied. Exact statement of place of death. Very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32542

## CERTIFICATE OF DEATH.

31 E 32542

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *60 Ridgely* ST. *75-32* WARD)2-FULL NAME *Harvee Wesley Burley*(Residence in Baltimore: No. *60 Ridgely* St.; *50* yrs., *12* mos., *17* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*Col*5-SINGLE, *married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Aug* *20*, 19*28*  
(Month) (Day) (Year)7-AGE, *49**50* yrs., *4* mos., *17* ds.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)*Laborer 40*  
*Brick yard*9-BIRTHPLACE,  
(State or Country),*md*

## 10-NAME OF FATHER,

*Harvee W Burley Sr*11-BIRTHPLACE OF FATHER  
(State or Country),*md*

## 12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER  
(State or Country),*md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harvee Burley Jr*(Address) *60 Ridgely St*

## 15-

APR 6 - 1928. HAMMON JONES, M.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*April* *3*, 19*28*.  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *12 W* 19*27*, to *April 3* 19*28*, that I saw *him* alive on *April 2* 19*28*, and that death occurred, on the date stated above, at *245 p* m.

The CAUSE OF DEATH\* was as follows:

*Tuberculosis of*  
*lungs. Free go.*  
(Duration) *6* yrs., *6* mos., *17* ds.CONTRIBUTORY  
(Secondary)(Signed) *R. M. Jones* M. D.  
*April 4*, 19*28*. (Address) *Luttrell*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs., *6* mos., *17* ds. In the State *4* yrs., *6* mos., *17* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*St. Luke's*  
20-UNDERTAKER *Samuel Easton*

## DATE OF BURIAL,

*4 - 6* 19*28*  
ADDRESS *116*

important. See instructions on back of certificate.

E 32543

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32543

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* 16-222-FULL NAME *Mrs. M. C. Gregor*(a) RESIDENCE NO. *822 N. Mount St.*

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *0* mos. *0* ds.ST. *16-22* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male*4 COLOR OR RACE *negro*5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Edith M. C. Gregor*6 DATE OF BIRTH (month, day, and year) *1898*

7 AGE

Years *30*Months *—*Days *—*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Labourer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *N. C.*10 NAME OF FATHER *John M. C. Gregor*11 BIRTHPLACE OF FATHER (city or town) (State or country) *N. C.*12 MAIDEN NAME OF MOTHER *not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *N. C.*

14

Informant *Edith M. C. Gregor*(Address) *10202 N. Mount St.*

Filed

19

C. HANCOCK JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/4/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *4/2/28*, 19 to *4/4/28*, 19 that I last saw him alive on *4/3/28*, 19 and that death occurred, on the date stated above, at *2100 ft* m.

The CAUSE OF DEATH\* was as follows:

*Tubercular pneumonia*CONTRIBUTORY (Secondary) *indian dilatation* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *H. Lawrence Fabiny*, M. D. (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Joseph's Hospital*

UNDERTAKER

ADDRESS *9th**Harriet Easton**Be are*

CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32544

## CERTIFICATE OF DEATH. X 51 E 32544

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Brune ST. 17-76 WARD)

## 2-FULL NAME Mildred E. Carme

(a) RESIDENCE NO. 611 Brune

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 4

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Carme

6 DATE OF BIRTH (month, day, and year) Mar. 17, 1888

7 AGE

Years 40

Months 0

Days 13

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co., Md.

10 NAME OF FATHER Mahlon Lykes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co., Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14

Informant (Address) Blanche Gray

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-1928

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1928, to April 5, 1928,

that I last saw her alive on April 5, 1928,

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH was as follows:

Acute Inflammatory Pneumonia

(duration)

yrs.

mos. 10

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 2

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marshall E. Conner

M. D.

19

(Address) 1845 N. Carroll St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Friendship Cemetery

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

H. M. Snyder

Mt. Airy, Md.

CAUSE OF DEATH IN PLAIN ENGLISH is very important. See instructions on back of certificate.

APR 6 - 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 32545

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *11 W. Heath* St. *23-3* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *11 W. Heath* St. *23-3* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S. if of foreign birth *50* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

March 16, 1928, to April 3, 1928

that I last saw him alive on April 3, 1928

and that death occurred, on the date stated above, at 9:45 A. M.

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis, with Heart Block and Auricular Fibrillation*

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Typical findings*(Signed) *Allen W. 7c* M. D.19 (Address) *1412 Light St. Baltimore*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

10 UNDERTAKER

ADDRESS

tion should be carefully supplied. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

APR 6 1928

Registrar

*Catholic Cem. Margaret J. Flynn**April 6, 1928 1412 Light St.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32540 DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital* ST *70-69* WARD)2-FULL NAME *Mr. Frank Ganth*(a) RESIDENCE NO. *415* *Tarrow* ST, WARD

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.*10* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *39* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Agnes Ganth*

6 DATE OF BIRTH (month, day, and year)

*Aug. 26, 1861*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*66**7**9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Butcher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Blasphor & Schaaf*

9 BIRTHPLACE (city or town) (State or country)

*Germany*

10 NAME OF FATHER

*Franz Ganth*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Mrs. Agnes Ganth*  
*415 Tarrow St*

15

Filed

190

*HAYES JONES, M.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4-4* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from

*4-2*, 19 *28*, to *4-4*, 19 *28*that I last saw him live on *4-4*, 19 *28*and that death occurred, on the date stated above, at *4:50 P* m

The CAUSE OF DEATH\* was as follows:

*Brachio. pneumonia*

CONTRIBUTORY (Secondary)

*Ch. Interstitial Nephritis*

(duration) ? yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Francis L. Pedeglidis* M. D., 19 (Address) *St. Agnes' Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cremation at Loudon Park*  
*Adel to Kennon, Wash. D.C.**April 7, 1928*

20 UNDERTAKER

*G. W. Dill*ADDRESS *3107**Neck Ave.*

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32547

## CERTIFICATE OF DEATH. X 90 E 32547

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 St. Paul

ST. 11-15 WARD)

## 2-FULL NAME

Anna Rebecca Brown

## (a) RESIDENCE NO.

918 St. Paul

ST. 11-15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

-- yrs. -- mos. 7

ds.

How long in U. S., if of foreign birth?

-- yrs.

-- mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

67

--

--

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Directress 096

(b) General nature of industry, business, or establishment in which employed (or employer)

Washington College

(c) Name of employer

Chestertown, Md.

## 9 BIRTHPLACE (city or town) (State or country)

Chestertown Maryland

## 10 NAME OF FATHER

Hiram Brown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Kent Co. Maryland

## 12 MAIDEN NAME OF MOTHER

Mary Merritt

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Kent Co. Maryland

## 14

Informant (Address)

Miss Mildred E. Wier 918 St. Paul Street

## 15

Filed

, 19

C. H. JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) Apr. 5, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from 4-5-28 to 4-5-28

that I last saw her alive on 4-5-28, 1928, and that death occurred, on the date stated above, at 3:40 p.m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration)

yrs.

6 mos.

ds.

## CONTRIBUTOR (Secondary)

Augma Pectoris

(duration)

yrs.

1 mos.

1 hr.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

W. H. Murphy, M. D.

, 19 (Address)

1403 Park Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Chestertown, Maryland

4/7 1928

## 20 UNDERTAKER

## ADDRESS

Cerryl W. Mears, Son 805 N. Lombard

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32548

## CERTIFICATE OF DEATH

REGISTERED NO.

E 32548

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *11-24* Ward)2-FULL NAME *Louise Amos*(a) RESIDENCE NO. *Lutherville Md.* Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred - yrs. - mos. *4* ds. How long in U. S. if of foreign birth? - yrs. - mos. - ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *C. H. Amos*6 DATE OF BIRTH (month, day, and year) *04 12 1889*

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER *A. R. Sperry*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER *Fannie Shipley*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address) *Hospital Records*15 Filed *APR 6 - 1928* 19Registrar *D. W. Hanson*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-5-28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*4-1-28*, 1928, to *4-5-28*, 1928that I last saw her alive on *4-5-28*, 1928and that death occurred, on the date stated above, at *1:15 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pregnancy**Chronic Nephritis*

CONTRIBUTORY (Secondary)

*Paralytic Pleurisy**Acute Cardiac Dilatation*

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *YES* Date of *4-2-28*Was there an autopsy? *NO* *Examination Section*What test confirmed diagnosis? *Clinical*(Signed) *Geo. A. Thompson*19 (Address) *1109 G. St. N. W.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Druid Ridge Cemetery* *4/7* 1928

20 UNDERTAKER

ADDRESS

*Wm. W. Mears and Son* *805 N. Calvert*

tion should be carefully supplied. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

E 32549

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4737 Park Heights ST. WARD 27-56)2. FULL NAME Robert Lee Hart Jr.(a) RESIDENCE NO. 4737 Park Heights ST.(Usual place of abode)  
Length of residence in city or town where death occurredyrs. 3 mos. 11 ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)  
yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32549

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 24 27

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.311

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Balti Md.

10 NAME OF FATHER

Robert Lee Hart11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Md.

12 MOTHER'S NAME

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Balti Md.

14

Informant  
(Address)Robert Lee Hart  
4737 Park Heights

15

Filed

PR 6 - 1928

19

C. H. JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 5 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 5 - 1928 to April 5 - 1928  
that I last saw him alive on April 5 - 1928  
and that death occurred, on the date stated above, at  
The CAUSE OF DEATH\* was as follows:Pneumonia Broncho

(duration)

yrs.

mos

3

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

C. Loring Johnson  
4612 (Address) Medicine Bldg

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

Woodlawn  
W. M. Boutson

ADDRESS

April 2 1928  
223 M  
Mitchell



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32550

## CERTIFICATE OF DEATH.

REGISTERED NO. 32550 J

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 4-30 Ward)2-FULL NAME Frances Humphrey Miller(a) RESIDENCE NO. 121 Broadway, Hagerstown, Md Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 23 Months 1 Days 22 IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown, Md  
(State or country)10 NAME OF FATHER S. Frank Miller11 BIRTHPLACE OF FATHER (city or town) Pa  
(State or country)12 MAIDEN NAME OF MOTHER Viola Burhane13 BIRTHPLACE OF MOTHER (city or town) N.Y.  
(State or country)14 Informant Mrs. Frank Miller  
(Address) Hagerstown, Md15 1828 C. HAMPTON JONES, M.D.  
RR 4 Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Brain Tumor

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)(Signed) Agnes Miller (duration) .....yrs. ....mos. ....ds.

(Coroner)

46, 1928 (Address) 2739 Eastern Ave\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVALHagerstown, Md Date of Burial April 9, 1928

20 UNDERTAKER

G. M. Suter & Sons ADDRESS Hagerstown, Md

tion should be carefully supplied. OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. very important.

E 32551

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32551

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITALCITY OF BALTIMORE: (No. 15-61 ST., WARD)2-FULL NAME Clara Huntington(a) RESIDENCE No. 1620 Clamont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 99 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/28/887 AGE Years 39 Months 3 Days 9 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerical

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md10 NAME OF FATHER Geo. Huntington11 BIRTHPLACE OF FATHER (city or town) (State or country) va12 MAIDEN NAME OF MOTHER Jessie Pink13 BIRTHPLACE OF MOTHER (city or town) (State or country) md14 Informant Records (Address) JOHNS HOPKINS HOSPITAL15 1928 CHAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 192817 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1928, to April 6, 1928, that I last saw her alive on April 6, 1928, and that death occurred, on the date stated above, at 2:15 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of inguinal glands - metastatic from carcinoma vulva.

(duration) yrs. mos. ds.

CONTRIBUTORY Nervous system (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? biopsy(Signed) F. D. Coman, M. D.4/6, 1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western Cem. April 7 1928

20 UNDERTAKER

ADDRESS

A. Howard Evans 35 E. 7th Ave

TION is very important. See instructions on back of certificate.

E 32552

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 32552

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 421 South Duncan St., 1-3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Rausch

(a) Residence No. 421 S. Duncan St., Ward.....  
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 10 mos. 26 ds. How long in U. S. if of foreign birth? 22 yrs. 12 mos. 26 ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female 4-COLOR OR RACE, white 5-Single, Married, Widowed, Divorced, (Write the word.)

5-If married, widowed, or divorced, HUSBAND of (or) WIFE of Leroy Rausch

6-DATE OF BIRTH (month, day and year) May 10 1906

7-AGE, 22 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or...min.:

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town), Balto Md (State or Country),

10-NAME OF FATHER, Herman Borkman

11-BIRTHPLACE OF FATHER (city or town), Germany (State or Country),

12-MAIDEN NAME OF MOTHER, Henrietta Radtke

13-BIRTHPLACE OF MOTHER (city or town), Germany (State or Country),

14- (Informant), Henrietta Borkman (Address), 421 South Duncan Street

15- C. HAMPSON JONES, M.D. Registrar

Filed 7 1928

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 6 1928

17- I HEREBY CERTIFY, That I attended deceased from April 2 1928 to April 6 1928

that I last saw her alive on April 2 1928

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH\* was as follows:

Pul. Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted at home If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical Signs

(Signed) C. Jones M. D.

4/6/28 (Address) 408 South An

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Green South Baltimore, Md. 1928

20-UNDERTAKER, August P. P. Address 406 Ashland Ave

E 32553

HEALTH DEPARTMENT—CITY OF BALTIMORE E 32553

CERTIFICATE OF DEATH. X 702

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home* ST., *6-4* WARD)

## 2. FULL NAME

*Vincent R. Peck*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*Mad. Side Md.* ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*1* yrs. *1* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*July 2-1907*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*30**9**3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Illinois*

## 10 NAME OF FATHER

*Maurice R. Peck*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Illinois*

## 12 MAIDEN NAME OF MOTHER

*Ethel Roberts*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Illinois*

## 14

Informant (Address)

*Maurice R. Peck  
Luther, Md.*

## 15

1928

*C. HAMPSON JONES, M. D.  
ROSA Registrar*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*April 5 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from *March 16, 1928* to *April 5, 1928*.

that I last saw him live on

*April 5, 1928*

and that death occurred, on the date stated above, at

*6:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*(Pancreatic)**Foreign body in intercostal tract (Gun knife)*

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

*General peritonitis*

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

*Yes, Date of 3/22/28*

Was there an autopsy?

*Yes*

What test confirmed diagnosis?

(Signed)

*W. E. Jones, M. D.*

, 19

(Address)

*Church Home & Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

*Hughes & Sons, Inc. 1000 Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



E 32554

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32554

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 703 N. Carey ST. 16-23

## 2. FULL NAME Catherine Rebecca Cohen

(a) RESIDENCE No. 703 N. Carey

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ST., WARD

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town  
(State or country))

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from  
 1928, to 1928  
 that I last saw him alive on 1928  
 and that death occurred, on the date stated above, at 8:20 P. m.  
 The CAUSE OF DEATH\* was as follows:

Organic Heart Disease  
 Indefinite  
 (duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What was confirmed diagnosis?

(Signed)

M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood by the layman.  
 TION is very important. See instructions on back of certificates.

1928

C. 19

HAMPSON JONES

Registrar

1620 E. Madison St.  
 1620 E. Madison St.

555

PLACE OF DEATH

County

Baltimore

Village or City

Siccing's Sanitarium  
Baltimore (No. 1, 2)STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

Ward

(If death occurred in  
a hospital or institu-  
tion, give its NAME in-  
stead of street and  
number.)

2 FULL NAME

Anna Maymcke

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED

OR DIVORCED

(Write the word)

Widow

6 DATE OF BIRTH

July 25, 1837  
(Month) (Day) (Year)

7 AGE

90  
21 yrs. 8 mos. 11 da. or min. ?  
If LESS than  
1 day... hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work

Housewife

(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF  
FATHER

John Rosendorf

11 BIRTHPLACE  
OF FATHER

(State or country)

Germany

12 MAIDEN NAME  
OF MOTHER

Not known

13 BIRTHPLACE  
OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ewald Maymcke

(Address) 2205 E. Federal St.

15

1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr. 5<sup>th</sup> 1928  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Feb. 16 1928, to Apr. 4, 1928,  
that I last saw him alive on Apr. 4, 1928,

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH was as follows:

Senile - Metabolic  
Schizophrenia  
(Duration) yrs. 7 mos. 7 da.Contributory  
SecondarySenility  
(Duration) yrs. 1 mos. 6 da.

(Signed) R. A. Maymcke M. D.

4/8 1928 (Address) 907 H. St.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury; and (2) whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ferts, or Recent Residents)

At place of death yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cemetery April 7, 1928

20 UNDERTAKER

ADDRESS

Mr. L. Miller &amp; Son 2334 Jefferson St.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

E 32556

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. 74E 32556

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 103 W. Monument St. 11-25)

2-FULL NAME Louise Clarkson Whitlock

(a) RESIDENCE NO. 103 W. Monument St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Geo. Whitlock

6 DATE OF BIRTH (month, day, and year)

July 7, 1849

7 AGE

Years

78

Months

8

Days

28

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Peter G. Sauerwein

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Balto.

12 MAIDEN NAME OF MOTHER

May Clarkson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Penn.

14

Informant (Address)

Mrs. Frank C. Bolton 103 W. Monument St.

15

FILED

G. HAMPTON JONES, M. D. 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 5, 1928

17

I HEREBY CERTIFY, That I attended deceased from

OCTOBER 13<sup>th</sup>, 1927, to APRIL 5<sup>th</sup>, 1928.

that I last saw her alive on Apr. 5, 1928.

and that death occurred, on the date stated above, at 8:40 P. M.

The CAUSE OF DEATH\* was as follows:

ARTERIO SCLEROSIS

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

CEREBRAL HEMORRHAGE

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Thomas T. Sheare, M. D.

Apr. 6, 1928 (Address) 905 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park Ave. 7 1928

20 UNDERTAKER

ADDRESS

John D. Mitchell &amp; Sons 1400 E. Pratt St.

This should be carefully supplied. Exact statement of occurrence of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. very important.

E 32557

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32557

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3219 Belmont Ave. 16-67 Ward)2-FULL NAME Ruth Harcup Adams(a) RESIDENCE NO. 3219 Belmont Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Adams6 DATE OF BIRTH (month, day, and year) Oct 13, 18447 AGE Years 83 Months 5 Days 23 IF LESS than 1 day... hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.10 NAME OF FATHER John Harcup11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.12 MAIDEN NAME OF MOTHER Ruth Johnson13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.14 Informant Chas E. Adams (Address) 3219 Belmont Ave

15 Filed

R 7 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5, 28 1917 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1927, to April 5, 1928. That I last saw him alive on Apr 5, 1928.and that death occurred, on the date stated above, at 10:00 m.

The CAUSE OF DEATH\* was as follows:

Chronic myo- and endo-  
carditis, arteriosclerosis,  
cerebral apoplexy(duration) 9 yrs. 9 mos. 10 ds.CONTRIBUTORY Recurrent cerebral apoplexy (Secondary)(duration) 10 yrs. 10 mos. 10 ds.

18 Where was disease contracted

if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical findings(Signed) Maurice E. Shannon M. D.(Address) 3300 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial April 9, 192820 UNDERTAKER John Mitchell ADDRESS 1000 E. Baltimore Ave



E 32558

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32558

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *12-19* Ward)2-FULL NAME *Mrs. J. M. Moseley*(a) RESIDENCE NO. *1823 Hillsord Ave* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced. (write the word)

*Female White Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER *Elias T. Cruise*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER *don't know*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

*Hospital Records*

15 Filed

R 7. 1928

16

*HAMPSON JONES M.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/4/28*

17 I HEREBY CERTIFY, That I attended deceased from

*11/17/28*, 19\_\_\_\_, to *4/4/28*, 19\_\_\_\_,that I last saw *h.k.y.* alive on *4/4/28*, 19\_\_\_\_,and that death occurred, on the date stated above, at *9:50* m.

The CAUSE OF DEATH\* was as follows:

*metastatic carcinoma*(duration) *2* yrs. mos. ds.CONTRIBUTORY *Cardiac Accom-*(Secondary) *pensation*

(duration) \_\_\_\_\_ yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? *Clinical*(Signed) *J. S. Whitehead*, M. D., 19\_\_\_\_ (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Greenmount Cemetery**April 7 1928*

UNDERTAKER

ADDRESS

*George W. Zirkler**1737 E. Eager*

THIS SHOULD BE CAREFULLY EXAMINED. Exact statement of occupation of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32559

E 32559

## CERTIFICATE OF DEATH.

101-807

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *807* WARD)2-FULL NAME *Thomas J. Harrahan*(a) RESIDENCE NO. *1834 N Chester* ST. *807* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed,  
or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Nettie Harrahan*6 DATE OF BIRTH (month, day, and year) *Aug. 29-1887*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work *Tailor*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *Balto, Md.*10 NAME OF FATHER *Joseph Harrahan*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Balto, Md.*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Not known*

14

Informant *Nettie Harrahan*  
(Address) *1834 N. Chester St.*

15

19 *1928*

Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/6* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 3*, 19 *28*, to *April 6*, 19 *28*.that I last saw him live on *Apr 6*, 19 *28*and that death occurred, on the date stated above, at *7 am*

The CAUSE OF DEATH\* was as follows:

*lobar pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY *Acute cardiac dilatation*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date of *No*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H Lawrence Fabney*, M. D., 19 (Address) *St Joseph's Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Baltimore Cem*

DATE OF BURIAL

*4/10* 19 *28*

20 UNDERTAKER

*George W. Zickler*

ADDRESS

*1737 E. Esqr*

TION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32560

## CERTIFICATE OF DEATH.

101-001  
E 32560

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1513 Mosher St., 16-22 Ward)

## 2-FULL NAME

Thos. Hayes

## (a) RESIDENCE NO.

1513 Mosher St., \_\_\_\_\_ WardLength of residence in city or town where death occurred 30 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

Col

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma Hayes

## 6 DATE OF BIRTH (month, day, and year)

Nov 23-1883

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.44 4 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Laborer

## 9 BIRTHPLACE (city or town) (State or country)

Va

## 10 NAME OF FATHER

Thos J Hayes

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Sarah G. Ford

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

## 14

Informant (Address)

Thos Hayes  
546 Mosher St

## 15

Date of death

Feb 23 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr 6 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an \_\_\_\_\_ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said \_\_\_\_\_ (Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Signed) F. B. Cook M. D.  
(Coroner)  
Apr 6 1928 (Address) North Ave & Division

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.  
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. John's Church  
Apr 7 1928

## 20 UNDERTAKER

Sam'l H. Chase & Son  
ADDRESS 1400 Mosher

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

32561

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32561

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1048 Patapsco*)2-FULL NAME *William B Jacobs*(a) RESIDENCE NO. *1048 Patapsco*

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *6* mos. *21* ds.

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

19 HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That a person deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32562

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 Edmondson Ave. ST. 16-22 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Marian V. Merriken

(a) RESIDENCE NO. 1918 Edmondson Ave

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 65 yrs. mos. ds.

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George Merriken

6 DATE OF BIRTH (month, day, and year) Jan 29, 1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

2

3

7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel County Md.

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Sarah A. Wittington

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel County

14 Informant Mr. John Ward (Address) 1800 W. Baltimore Street

15 1928 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1928

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18-1926 to April 6-1928, that I last saw her alive on April 6, 1928, and that death occurred, on the date stated above, at 7.40 A.M.

The CAUSE OF DEATH\* was as follows:

Splenomyelogenous Leukemia.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

4/10/28 J. M. Jones, M. D.

(Address) 2125 Maryland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Greenmount Cemetery

20 UNDERTAKER

Suplt Cook

DATE OF BURIAL

Apr. 9, 1928

ADDRESS

1003 West Baltimore St

CAUSE OF DEATH IN plain terms, so that it may be understood by the layman. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32563

## CERTIFICATE OF DEATH.

E 32563

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *516 Ravenwood* ST. *27-48* WARD)2-FULL NAME *Anna Lavina Sparks*(a) RESIDENCE No. *516 Ravenwood* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of or WIFE of *and John H. Sparks*6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years *77*

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Texas Md*10 NAME OF FATHER *Geo. L. Anderson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Ruth Dawson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *Mrs. M. L. Fowler*

15

FILE *1928*

G. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 5* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *Dec 17*, 19*27*, to *Apr 5*, 19*28*,that I last saw her alive on *Apr 5*, 19*28*and that death occurred, on the date stated above, at *9:25* p. m.

The CAUSE OF DEATH\* was as follows:

*Heart trouble (Senile)*CONTRIBUTORY (Secondary) *Paralysis of throat* (duration) *1* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *E. H. Duncan*, M. D.19 (Address) *5106 York Road*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER *Removethon*ADDRESS *3415 Chestnut*

TION is very important. See instructions on back of certificate.

E 32564

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32564

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Cherry Hill* ST. *25-32* WARD *159-002*)

## 2. FULL NAME

(a) RESIDENCE No. *Cherry Hill Medical* ST. *159-002* WARD *159-002*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male* *White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Child*

6 DATE OF BIRTH (month, day, and year)

*Mar 20 1928*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*17**17*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*Edw Bathum*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md*

12 MAIDEN NAME OF MOTHER

*Josephine Gaudin*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md*

14

Informant (Address)

*Edw Bathum*  
*Cherry Hill Baltimore*

15

1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 20 1928* to *April 6 1928*.that I last saw him alive on *April 5 1928*.and that death occurred, on the date stated above, at *10-30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Bronchopneumonia*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*H. M. Kieffer* M. D.1928 (Address) *2320 Washington Blvd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral Cem.**April 7, 28*

20 UNDERTAKER

ADDRESS

*F. A. Krause & Son* *703 Hanover*

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32565

E 32565

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 5. Fairview St. 12-50 Ward)2-FULL NAME Stephen C. Lieben(a) RESIDENCE NO. 5. Fairview St. 12 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie C. Lieben

6 DATE OF BIRTH (month, day, and year)

Jan 24 18887 AGE Years 70 Months 2 Days 6 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pca (State or country)10 NAME OF FATHER Edward Lieben11 BIRTHPLACE OF FATHER (city or town) (State or country) Pca12 MAIDEN NAME OF MOTHER Marianne

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Annie Lieben (Address) 5. Fairview St.15 Filed G. HAMPTON JONES M. D. RegistrarREGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Ischaemic Disease of Heart (duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Morris M. D. (Coroner)(Address) 7632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death:

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holly Redeemer Cem Date of Burial Apr 8 1928

20 UNDERTAKER

E. L. Roy Address 1255 North Ave

OF DEATH in plain terms, so that it may be properly classified. Enter statement of cause of death on back of certificate. very important. See instructions on back of certificate.



E 32566

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

43 E 32566

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital 7-25* WARD)2-FULL NAME *Klara Bauer*(a) RESIDENCE NO. *502 Ogden*

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Cal*

5 Single, Married, Widowed, or divorced, (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

LESS than day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

1928

G. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-5-1928*

17

I HEREBY CERTIFY, That I attended deceased from *9-19-1927* to *4-5-1928* that I last saw *h* alive on *4-5-1928* and that death occurred, on the date stated above, at *1:30* m.

The CAUSE OF DEATH\* was as follows:

*Coronary & Lung disease and fall*

CONTRIBUTORY (Secondary)

*Pneumonia* (duration) yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 32567

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32567

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Baltimore City Hospitals (T-11) ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Slifker

(a) RESIDENCE No. 808 N. Curley st.

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884 1874

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 54

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Pete Slifker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Anna Kerowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant. Hospital Records (Address)

15 Filed 1928 G. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1928, to April 5, 1928,

that I last saw him alive on April 5, 1928,

and that death occurred, on the date stated above, at 2:20 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Tuberculous Laryngitis

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Madden, M. D.

4-5-1928 Address Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32568

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1533 Halbrook*ST. *9-18* WARD)2-FULL NAME *Elizabeth S. Jewell*(a) RESIDENCE NO. *1533 Halbrook*

(Usual place of abode)

Length of residence in city or town where death occurred *56* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Thomas J. Jewell*6 DATE OF BIRTH (month, day, and year) *Nov 28 1849*

7 AGE

Years *78*Months *4*Days *6*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Va*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va*

14

Informant (Address) *William J. Jewell 1533 Halbrook St*

15

Filed

1920 C. HAMFSON JONES M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 4 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 1, 1928* to *April 4, 1928*, that I last saw her alive on *April 4, 1928*, and that death occurred, on the date stated above, at *2:15 P* m.

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical signs*(Signed) *J. Lee Magness*, M. D.*4/6, 1928* (Address) *1206 E. Preston St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St. Carmel**4/7 1928*

20 UNDERTAKER

ADDRESS

*Wm. Cook**522 E. North Ave*

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE.

32569

## CERTIFICATE OF DEATH.

E 32569

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *16* WARD) *67*2-FULL NAME *Miss Katherine Morrow*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *3034 Belmont Ave* ST. *16* WARD *67*

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan. 6, 1868*7 AGE Years *60* Months *3* Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Pa*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Pa*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Pa*

14

Informant *Mary D. Lilly*  
(Address) *3034 Belmont Ave*

15

Filed *1925* 19 *RAMPSON JONES, M. D.* Registrar *RPA*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 6, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 7*, 1928, to *April 6*, 1928.that I last saw her alive on *April 6*, 1928.and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Arterio-sclerotic gangrene both lower extremities. Cardio-vascular disease*(duration) yrs. *6* mos. ds.CONTRIBUTORY (Secondary) *Senility*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *3034 Belmont Ave.*Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *Chemical*(Signed) *Lewis Elds Vignette*, M. D., 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

DATE OF BURIAL

*St. Claret**4/9 1928*

20 UNDERTAKER

ADDRESS

*Wm Cook**3825, 12th Ave*

TION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32570

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Wd Gen Hosp 70-78* St. *70-78* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *535 Pulaski* St. *70-78* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 11 1912*7 AGE Years *15* Months *7* Days *25* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## PARENTS

14

Informant (Address)

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E 32571

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH *St. Joseph's Hosp.*CITY OF BALTIMORE: (No. *1-3*)2-FULL NAME *Angeline Trocki*(a) RESIDENCE NO. *818 South Milton Ave.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 3 1927*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*9**3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Frank Trocki*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Poland*12 MAIDEN NAME OF MOTHER *Angeline Wiclonska*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Poland*

14

Informant (Address)

*Frank Trocki**818 S Milton Ave.*

15

*G. HAMPSON JONES M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 6, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 18, 1928*, to *April 6, 1928*, that I last saw her alive on *April 6, 1928*, and that death occurred, on the date stated above, at *6.30 PM*

The CAUSE OF DEATH\* was as follows:

*Empyema (Pneumococci)*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *April 2, 1928*Was there an autopsy? *NO*What test confirmed diagnosis? *Clinical*(Signed) *T. P. Thompson* M. D., 19 (Address) *St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Rosary Cem.**April 7 1928*

20 UNDERTAKER

ADDRESS

*John M. Weber 401 Chester*

TION is very important. See instructions on back of card.

E 32572

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32572

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1752 Clarkson St

ST. 23-32 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Banner

(a) RESIDENCE NO. 1752 Clarkson St ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	24	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa.  
(State or country)

10 NAME OF FATHER William Banner

11 BIRTHPLACE OF FATHER (city or town) Pa.  
(State or country)

12 MAIDEN NAME OF MOTHER Pauline Keller

13 BIRTHPLACE OF MOTHER (city or town) Balto.  
(State or country)14 Informant Edward Banner  
(Address) Brooklyn A. A. Co.

15 File 1928 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 1, 1928, to April 6, 1928  
that I last saw him alive on April 5, 1928  
and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.  
CONTRIBUTORY acute dilatation of heart  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemistry

(Signed) R. H. Campbell, M. D.  
128 (Address) 1644 Leavitt St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cedar Hill Cemetery

Apr 9 1928

20 UNDERTAKER

ADDRESS

J. Frew M. G. mly

130 E. Fort

LAMMERS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32573

## CERTIFICATE OF DEATH

90 E 32573

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3606 Fernwood Ave. St. 16637)2-FULL NAME Joseph David Lammers(a) RESIDENCE NO. 3606 Fernwood Ave. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. (If non-resident give city or town and State)How long in U. S. if of foreign birth 60 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of (or) WIFE of The late Jannetta Lammers6 DATE OF BIRTH (month, day, and year) Dec. 30 / 18577 AGE Years 70 Months 3 Days 5 IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER Don't Know11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Don't Know13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Helen A. Behringer (Address) 3410 Harwood Ave15 1928 C. HAMMOND JONES Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 19 2817 I HEREBY CERTIFY, That I attended deceased from 3/21, 1928, to 4/4, 1928, that I last saw him alive on 4/4, 1928.and that death occurred, on the date stated above, at 12/10 m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis  
Myocarditis

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Sacred Heart CemeteryApril 8 19 28

20 UNDERTAKER

Lilly & Ziehl Inc

ADDRESS

403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32574

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITALCITY OF BALTIMORE: (No. 101-001)ST. 10 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Baumer(a) RESIDENCE NO. 105 S Curley

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 18 mos.ST. 1 WARD

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female whitechild

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

8/27/26

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1189

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

Thomas Baumer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind

12 MAIDEN NAME OF MOTHER

May Baumer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

1928C. HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1928, to April 6, 1928, that I last saw him alive on April 6, 1928, and that death occurred, on the date stated above, at 5:17 A m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumoniaCONTRIBUTORY (Secondary) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? yrs. mos. ds.

HomeDid an operation precede death? No Date of —Was there an autopsy? YesWhat test confirmed diagnosis? Ray

(Signed)

Alvan Blodson

M. D.

4/6, 1928 (Address) The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer CemeteryApril 8, 1928

UNDERTAKER

Killy, John

ADDRESS

400 S. W. 1st St

E 32575

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 32575

1-PLACE OF DEATH Pronounced dead at  
City of BALTIMORE: (No. Hopkins Hospital St. 1-3 Ward)

2-FULL NAME Evelyn Bulmash

(a) RESIDENCE NO. 2125 E. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 8/1926

7 AGE Years 2 Months 0 Days 29 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER Myer Bulmash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sophia Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Sol Levinson

(Address)

1127 E. Balto. St.

15 1926 16 HAMPSON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1926 Apr 6/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Probably Lobar)

(duration) yrs. 1 mos. ds. CONTRIBUTORY Pleurisy (Secondary)

(Signed) J. S. Hatter M. D. (Coroner)

4/6/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death dead on arrival yrs. mos. ds.

Where was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Hebrew Mt Carmel 4/8/28

20 UNDERTAKER ADDRESS 1127 E

Hampson Jones

OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

E 32576

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32576

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *810 P. Bond* St. *2-4* Ward *7*)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) Residence No. ....

(Usual place of abode)

St. ....

Ward ....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. ....

mos. ....

ds. ....

Now long in U. S. if of foreign birth?

yrs. ....

mos. ....

ds. ....

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Male*

4-COLOR OR RACE,

*White*5-Single, *Single*  
Married,  
Widowed,  
or Divorced,  
(Write the word.)5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

*Nov. 1-1927*

7-AGE,

*5*

If LESS than 1 day,

yrs. .... mos. .... ds. ....

hrs. or .... min. ?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work. ....(b) General nature of industry,  
business, or establishment in  
which employed (or employer) ....

(c) Name of employer. ....

9-BIRTHPLACE (city or town),  
(State or Country),*Baltimore, Md*10-NAME OF  
FATHER,*Joe Kazimierski*11-BIRTHPLACE  
OF FATHER (city or town),  
(State or Country),*Poland*12-MAIDEN NAME  
OF MOTHER,*Mary Jaszkowski*13-BIRTHPLACE  
OF MOTHER (city or town),  
(State or Country),*Baltimore*

14-

(Informant)

(Address)

*M. Jaskowski**810 P. Bond, 28*

15-

Filed

1928

HAMPSON JONES, M. D.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year).

*4-7-28*

17- I HEREBY CERTIFY, That I attended deceased from

*April 5*, 19*28*, to *April 7*, 19*28*that I last saw him alive on *April 7*, 19*28*and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Measles*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY *Broncho Pneumonia*  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Andrew Thompson*, M. D.*4/7*, 19*28* (Address) *2529 Eastern av*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL,

*St. Mary's Cemetery, April 7, 1928*

20-BURIAL

ADDRESS

*St. Mary's Cemetery*

Instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

2/2489  
E 32577

## CERTIFICATE OF DEATH.

X 129 E 32577

1-PLACE OF DEATH JOHNS HOPKINS HOSPITALCITY OF BALTIMORE: (No. 74)ST. 74 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanch Geyer(a) RESIDENCE No. Remick

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ST.

WARD West-2a

(If non-resident give city or town and State)

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

West-2a -10 NAME OF FATHER Wm B. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

W-2a -12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

W-2a -

14

Informant (Address)

Records - JOHNS HOPKINS HOSPITAL

15

Filed

19

Per

G. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 26, 1928, to April 7, 1928.that I last saw her alive on April 7, 1928,and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage(duration) yrs. mos. 12 mos.

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Williams M. D.

4-7-1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Remick W 2a4/7/28

20 UNDERTAKER

ADDRESS

Joseph Ahrens221 Bway



E 32578

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2804 Hollyon Park Rd. Bk. 7-44* WARD)2-FULL NAME *William Frederic Fubking*(a) RESIDENCE NO. *2804 Hollyon Park Rd.* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *39* yrs. *8* mos. *8* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (name of)

*Florence E. Fubking*6 DATE OF BIRTH (month, day, and year) *July 28 1889*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*39**8**8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Manager*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Loan Business*

(c) Name of employer

*Walter E. McDaniel*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Julius Fubking*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore*

12 MAIDEN NAME OF MOTHER

*Mary E. Welch*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore*

14

Informant (Address)

*Edmund Fubking*

15

FILE

1928

G. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 5 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March*, 1928, to *April 5*, 1928, that I last saw him alive on *April 5*, 1928, and that death occurred, on the date stated above, at *10:35* p. m.

The CAUSE OF DEATH\* was as follows:

*Infectious Toxic Cellulitis*

CONTRIBUTORS (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

7.7. 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*London Park* *April 9 1928*  
*W. J. McMan* *928 Broadway*

E 32579 HEALTH DEPARTMENT—CITY OF BALTIMORE E 32579

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 N. Calhoun

ST. 19-27 WARD)

2. FULL NAME Ida Hall

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 430 N. Calhoun

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life time

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1, 1865

7 AGE Years 62 Months 4 Days 0 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

Charles C. Feldman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Ida Joseph Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

unknown

14

Informant (Address)

Mrs. Annie Smith 430 N. Calhoun St.

15

1928

19

HAMPSON JONES, D. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1928, to April 5, 1928,

that I last saw her alive on April 2, 1928

and that death occurred, on the date stated above, at 12.30 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Mary Mead Dean, M. D.

, 19

(Address) 901 N. Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Asbury Cemetery

April 9, 1928

20 UNDERTAKER

ADDRESS

Mrs. Charles H. Bailey 1421 Jefferson St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32580

## CERTIFICATE OF DEATH.

E 32580

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 E Hamburg ST. 24-33 WARD)

## 2-FULL NAME Alice L. Hirsch

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 104 E Hamburg

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1854

7 AGE

Years 70

Months 5

Days 29

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

10 NAME OF FATHER Charles H. Hirsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Ebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14

Informant (Address) John Byrne 104 E Hamburg St

15

Filed

1928

19

DANFORD

M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1928, to April 6, 1928, that I last saw her alive on April 6, 1928, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis

CONTRIBUTORY (Secondary) - Chronic Bright Disease (duration) yrs. 6 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. White

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32581

## CERTIFICATE OF DEATH

E 32581

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *26 Mason St* St. *18* Ward *18*)2-FULL NAME *Andrew M. Schultz*(a) RESIDENCE NO. *26 Mason St* St. *18* Ward *18*

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 Color or Race *W*5 Single, Married, Widowed, or Divorced. (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 25, 1927*

7 AGE

Years

Months *8*Days *15*

IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *Balto md*10 NAME OF FATHER *Michael Schultz*

11 BIRTHPLACE OF FATHER (City or town)

(State or country) *Balto md*12 MAIDEN NAME OF MOTHER *Minnie Mauer*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Balto md*

14

Informant (Address) *Michael Schultz*  
*26 Mason St*

15

*1928* *HAMMON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 6 - 1928*

17

I HEREBY CERTIFY, That I attended deceased from *4/5 - 1928*, to *4/6 - 1928*, that I last saw him alive on *4/6 - 1928*and that death occurred, on the date stated above, at *9:00* m.

The CAUSE OF DEATH\* was as follows:

*Malice*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Was there an operation precede death? *No* Date of *4/5 - 1928*Was there an autopsy? *No*What test confirmed diagnosis *Chemical*(Signed) *W. H. Jones*

. 19

(Address) *134 S. Charles*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Holy Cross Brooklyn**4/8 1928*

20 UNDERTAKER

ADDRESS

*Wm Cook**502 E North*

OF DEATH in plain terms, so that it may be properly understood very important. See instructions on back of certificates.



32582

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32582

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 14-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Sheldon(a) RESIDENCE No. 1627 W. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-9-747 AGE Years 53 Months 4 Days 13 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md10 NAME OF FATHER John C. Sheldon11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md12 MAIDEN NAME OF MOTHER Mary C. Welch13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14

Informant (Address) Records

15

1926C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 11, 1919, to Apr. 5, 1928that I last saw him on Apr. 5, 1928and that death occurred, on the date stated above, at 4:30 A. M.

The CAUSE OF DEATH\* was as follows:

Stenoplegic - right - cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

arteriosclerosis yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? general + sub(Signed) C. J. Stelmus M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Thos. J. Schuman Apr 7, 1928 1839

E 32583

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32583

## CERTIFICATE OF DEATH

1-PLACE OF DEATH Balto City Hospital  
 CITY OF BALTIMORE: (No. 13alto md ST. 26-37 WARD 100)  
 2-FULL NAME William Claassen  
 (a) RESIDENCE No. Unknown ST.          WARD           
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed  
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown  
 6 DATE OF BIRTH (month, day, year) Unknown 1863  
 7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
65

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-1928  
 17 I HEREBY CERTIFY, That I attended deceased from 3-28-1928 to 4-6-1928 that I last saw him alive on 4-6-1928 and that death occurred, on the date stated above, at 2:30 P.M.  
 The CAUSE OF DEATH\* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos. ds.  
 CONTRIBUTORY Rephosis of Cerebral Arteries  
 (Secondary) Sclerosis  
 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings  
 (Signed) Philip Pearlman M. D.

4/7, 1928 (Address) Baltimore City Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Plainfield, N.J.  
 Undertaker E. J. Bartley

4/7/28  
 Address Shelburne

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32584

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 32584

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hospital* ST. WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed,  
or Divorced, (write the word)

✓

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 16, 1927

7 AGE

Years

Months

Days

21 If LESS than  
1 day, hrs  
or min.

4

22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

10 NAME OF FATHER

William Hopper

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Madeline Dew

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Maryland

14

Informant  
(Address)

Mother

15

Filed

19

R. C. K. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 7 1928

17

I HEREBY CERTIFY, That I attended deceased from

Nov 27, 1927, to April 7, 1928,

that I last saw him alive on April 7, 1928,

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia - Bacterial

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Geraghty, M. D.

4/7, 1928 (Address) Union Memorial Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Baltimore Carr

DATE OF BURIAL

4-9-28

20 UNDERTAKER

Henry W. Jenkins &amp; Sons

ADDRESS

2200 E. Charles

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32585

32585

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Cambridge City*  
 CITY OF BALTIMORE: (No. *34 s Charles*) ST. *4-30* WARD  
 2-FULL NAME *Hannah Ann Stran McCurley*  
 (a) RESIDENCE NO. *34 s Charles* ST. WARD  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced  
 (or) WIFE of *Late Isaac McCurley*

6 DATE OF BIRTH (month, day, and year) *July 10 1846*

7 AGE *81* Years *82* Months *27* Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at Home*  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9 BIRTHPLACE (city or town) *Balto Md.*  
 (State or country)

10 NAME OF FATHER *Mr H. Stran*

11 BIRTHPLACE OF FATHER (city or town) *Balto Md.*  
 (State or country)

12 MAIDEN NAME OF MOTHER *Ann M. Littig*

13 BIRTHPLACE OF MOTHER (city or town) *Balto Md.*  
 (State or country)

14 Informant *Mrs. Summers*  
 (Address) *Cambridge City*

15 Filed *G. HAMPTON JONES, M.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/7* 19 *28*

17 I HEREBY CERTIFY, That I attended deceased from *Sep 19<sup>th</sup>* 19 *25* to *Apr 7<sup>th</sup>* 19 *28*,  
 that I last saw her alive on *Apr 6<sup>th</sup>* 19 *28*,  
 and that death occurred, on the date stated above, at *12:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Arterial sclerosis accompanied by high blood pressure; partial paralysis.*

CONTRIBUTORY *Coma, urinary complete paralysis*  
 (Secondary) (duration) *2* yrs. *6* mos. *✓* ds.  
 (duration) yrs. mos. *12* ds.

18 Where was disease contracted *✓*  
 if not at place of death?

Did an operation precede death? *no* Date of *✓*

Was there an autopsy? *no*

What test confirmed diagnosis? *usual physical exams*  
 (Signed) *J. H. B. E. Seegar* M. D.

(Address) *904 N. Charles St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Greenmount Cem*  
 UNDERTAKER

*April* 19 *28*

ADDRESS

*Henry Jenkins & Co*

*Balto Md*

TION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32586

## CERTIFICATE OF DEATH.

E 32586

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 4-30 Ward)2-FULL NAME Edward Reissnyder(a) RESIDENCE NO. Lorsey, Md St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) March 10-18777 AGE 51 Years 56 Months x Days 28 IF LESS than 1 day.....hrs. or.....min.8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer B & C. R. K

9 BIRTHPLACE (city or town) \_\_\_\_\_

(State or country) Md10 NAME OF FATHER Valentine Reissnyder

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_

(State or country) Germany12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_

(State or country) Germany14 Informant Edward N. Fisher(Address) Lorsey, Md

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_

(Signed) Edward N. Fisher (Coroner) M. D.4/8, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the state.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorsey Md. Date of Burial 4-10 192820 UNDERTAKER Edward N. Fisher ADDRESS Lorsey Md

OF DEATH IN PAIR CASES, See Instructions on back of certificate.

APR 8 - 1928

C. HANSON JONES, M. D.

Registrar

E 32587

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 32587

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Ashland Ave. ST. 7-13 WARD)

2-FULL NAME Nelson Spady

(a) RESIDENCE No. 1504 Ashland Ave

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of ~~or wife of~~

Ella Spady

6 DATE OF BIRTH (month, day, and year) Mar. 31, 1868

7 AGE

Years

Months

Days

60 yrs

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self.

9 BIRTHPLACE (city or town) (State or country)

Cambridge Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Ella Spady 1504 Ashland Ave.

15

Filed

1923

G. HAMMOND JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5<sup>th</sup> 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1928, to April 5, 1928, that I last saw him alive on April 5, 1928, and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis, Anemia.

CONTRIBUTORY (Secondary) Myocarditis (duration) 1 yrs. 3 mos. - ds.

18 Where was disease contracted if not at place of death? Balto. (duration) yrs. 6 mos. ds.

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Kidney function test. (Signed) Calvin D. LeCompte

M. D. 19 (Address) 814 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathary Cemetery

DATE OF BURIAL

Apr 8 1928

UNDERTAKER

Robert William 1515 Military St

E 32588

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32588

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## CITY OF BALTIMORE: (No.

ST. 7-9 WARD)

## 2. FULL NAME

Morris Friedman

## (a) RESIDENCE NO.

(Usual place of abode)

Annapolis, Md

ST. WARD

Length of residence in city or town where death occurred

yrs.

mos.

16

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

April 15, 1902

## 7 AGE

Years

Months

Days

21 If LESS than 1 day, hrs. or min.

25

11

22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Md

## 10 NAME OF FATHER

Benjamin

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Fannie Feldman

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

## 15

APR 8 1928

AMMON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

4/6 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

March 21, 1928, to April 6, 1928,

that I last saw him alive on April 6, 1928,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH\* was as follows:

Thrombosis &amp; translocation

(duration)

yrs.

mos.

20

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

10

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

yes Date of 3-18-28

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4/6, 1928

(Address)

J. H. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Hebrew Mt. Cemetery

4/8 1928

## UNDERTAKER

## ADDRESS

Jack Lewis 1439 E. Baltimore

32589

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32589

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Sydenham Hospital

10-001

CITY OF BALTIMORE: (No.)

2-FULL NAME

Myer Kellman

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2019 Christian

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs. mos. ds.

ST.

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Child

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 23-1924

7 AGE

Years

Months

Days

3

6

15

If LESS than  
1 day. hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

Abraham Kellman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md

12 MAIDEN NAME OF MOTHER

Dla Zeltow

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md

14

Informant (Address)

Sydenham Hosp. Record

15

APR 8 1928

JONES, M. Registrar

20-28

ST.

WARD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/7 1928

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1928 to April 7, 1928,

that I last saw him alive on April 7, 1928,

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Culture

(Signed) Dr. Sachman, M. D.

4/7, 1928 (Address) Sydenham Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Greenwash Road

DATE OF BURIAL

4/8 1928

20 UNDERTAKER

Jack Lewis 1439 E. BALD



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32590

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3518 Reisterstown Rd. ST. 15-58 WARD 6)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Bella Carmel(a) RESIDENCE NO. 3518 Reisterstown Rd. ST. 15-58 WARD 6

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph Carmel

6 DATE OF BIRTH (month, day, and year)

August 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E. Baltimore St.

15

Filed

192819 C. HARRISON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/819 28

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1927 to April 7, 1928, that I last saw her alive on April 7, 1928, and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH\* was as follows:

Myocarditis(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

Clinical

(Signed)

W. J. B. M. D.4/8, 1928 (Address)2040 Kalam Pl

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hehren Herron Run4/8 19 28

UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32591

## CERTIFICATE OF DEATH.

44 E 32591  
REGISTERED NO.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lake Drive Apt. 20-54 ST. 20 WARD 54)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Marcus(a) RESIDENCE NO. Lake Drive Apt. 20 ST. 20 WARD 54

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 63 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMinnie H. Marcus6 DATE OF BIRTH (month, day, and year) Nov. 18 1852

7 AGE

Years 75Months 4Days 19If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Germany10 NAME OF FATHER Henry Marcus11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany12 MAIDEN NAME OF MOTHER Hena Samuel13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany

14

Informant  
(Address) Mr. M. Marcus  
Lake Drive Apt.

15

Filed

APR 8 1928

C. HASTON JONES  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7/ 19 28

17

I HEREBY CERTIFY, That I attended deceased from Oct 24, 19 27, to April 7, 19 28.that I last saw him alive on April 7, 19 28.and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of LiverSymptoms  
(duration) yrs. 7 mos. — ds.CONTRIBUTORY  
(Secondary) Pneumonia(duration) yrs. — mos. 3 ds.18 Where was disease contracted  
if not at place of death? —Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Clinical findings.  
No evidence of Carcinoma  
in any other organ than the liver  
(Signed) Louis P. Hamburger, M. D., 19 (Address) 1207 Eutaw Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Bruce Ridge Cem.DATE OF BURIAL 4/9/2820 UNDERTAKER David SondheimADDRESS 115-30 W. Mt.Royal Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32592

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital* ST. *10-14* WARD)2. FULL NAME *Mrs Emma Griffith*(a) RESIDENCE No. *1047 Airquith* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Lifetime* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John J. Griffith*6 DATE OF BIRTH (month, day, and year) *Nov 19-1846*7 AGE Years Months Days *81* *4* *19* If LESS than 1 day, hrs or min

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Maryland*10 NAME OF FATHER *John J. Griffith*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Maria E. Hughes*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *J. M. Griffith 516 Willow Ave*

15

Filed

APR 8 1928

G. H. JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 7 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*4-2*, 19 *28*, to *4-7*, 19 *28*that I last saw her alive on *4-7*, 19 *28*and that death occurred, on the date stated above, at *5.30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *4**Broncho-pneumonia* (duration) yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Francis L. Sadykian*, M. D., 19 (Address) *St Agnes Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Cathedral Cemetery* *Apr 9-1928*

20 UNDERTAKER

ADDRESS

*Chas P. Evans & Son 118 Wmth Royal Ave*

## HEALTH DEPARTMENT-CITY OF BALTIMORE

E 32593

## CERTIFICATE OF DEATH

100-001 E 32593

## 1-PLACE OF DEATH

Colonial Hospital

REGISTERED NO.

City of BALTIMORE: (No. 1122 N. Mount St. 15-58 Ward)

## 2-FULL NAME

Mr. Louis Franklin

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

2904 Keyworth Ave

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

38

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 Color or Race

white

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Fannie married

## 6 DATE OF BIRTH (month, day, and year)

April 4-1875

## 7 AGE

53 yrs

Years

Months

Days

IF LESS than 1 day... hrs. or min..

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Prussia

## 10 NAME OF FATHER

Meyer Mitchell

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Prussia

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hospital Records

## 14

Informant (Address)

## 15 Filed

19

J. H. JONES, N. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

4-7 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

3-29, 1928, to 4-7, 1928.

that I last saw him alive on 4-7, 1928.

and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 9 da.

## CONTRIBUTORY (Secondary)

Toxic Myocarditis

(duration) yrs. mos. da.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical &amp; Blood Pressure

(Signed) Julius S. Schlosberg, M. D.

19 (Address) Colonial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL CREMATION OR REMOVAL

Hebrew Friendship

Date of Burial

4/8 1928

## 20 UNDERTAKER

Jann Lewis

ADDRESS

1439 E. 30th



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32594

## CERTIFICATE OF DEATH.

166 E 32594

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

Mercer Hospital 15-61 St. Ward

## 2-FULL NAME

Norman S Suter (enter)

(a) RESIDENCE NO.

3503 Walbrook St.

Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 9, 1904

7 AGE

Years

Months

Days

24

8

27

IF LESS than 1, day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

10 NAME OF FATHER

J. W. Suter

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER

Minnie Thope

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

14

Informant (Address)

J. W. Suter 3503 Walbrook

APR 8 - 1928

HARRISON JONES, Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 6, 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Rachionide by drug (poisoning)

11 hrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Influenza

(Signed)

W. J. P. (Coroner)

Address

639 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Lorraine Cemetery

4/8 1928

20 UNDERTAKER

Wm Cook

ADDRESS

502 E. North

E 32595

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32595

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Memorial Hospital*CITY OF BALTIMORE: (No. *33rd Calvert St* ST. *27-53* WARD)2-FULL NAME *Halter 1st von Schnicker*(a) RESIDENCE NO. *202 Edgemoor Rd.* ST. *Ward*(Usual place of abode) *Edgemoor Rd.* (If non-resident give city or town and State)Length of residence in city or town where death occurred *30* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mrs. Isabel Brenner*6 DATE OF BIRTH (month, day, and year) *Feb 5, 1868*7 AGE Years *60* Months *2* Days *1* If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Dentist*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Harrisburg Md.* (State or country)10 NAME OF FATHER *Mr. W. von Schnicker*11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)12 MAIDEN NAME OF MOTHER *Brenner*13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)14 Informant *Isabel von Schnicker* (Address) *202 Edgemoor Road*15 *1928* *HANCOCK*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 7 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 6, 1928*, to *April 7, 1928*, that I last saw him alive on *April 6, 1928*, and that death occurred, on the date stated above, at *6:10 A.M.*

The CAUSE OF DEATH\* was as follows:

*Hæmorrhage from esophageal varices secondary to cirrhosis of liver.* (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *not known*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical exam.*(Signed) *James Arthur Weenber*, M. D., 19 *1928* (Address) *Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Druid Ridge*  
UNDERTAKER, *William Cook*

DATE OF BURIAL

*4/9 28*  
ADDRESS*502 E North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32596

## CERTIFICATE OF DEATH.

90 E 32596

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Ellwood - 2 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 602 S. Ellwood WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Beckia Kalus*6 DATE OF BIRTH (month, day, and year) *Sept 8 1884*7 AGE Years *43* Months *6* Days *28* LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Beekeeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *None*9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Frank Kalus*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Mrs. Kalus*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

## 14

Informant (Address) *Beckia Kalus*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 6 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 10 1928* to *April 6 1928* that I last saw him alive on *April 6 1928* and that death occurred, on the date stated above, at *9 a* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Bronchitis*

CONTRIBUTORY (Secondary)

(duration) *Gradual* yrs. mos. ds. *Chronic Myocarditis* (duration) *Gradual* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Observation*(Signed) *Harace B. Titlow* M. D. 1928 (Address) *35 S. Highland Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

UNDERTAKER

ADDRESS

APR 8 1928

HARRY JONES, M. D. Registrar

*Carroll* *April 10 1928* *William 502 E. Hall*

E 32597

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

162  
E 32597  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 229 S Washington St. 4 Ward)2-FULL NAME Baby Kusyk(a) RESIDENCE NO. 229 S Washington St. 4 Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 Color or Race White5 Single, Married, Widowed,  
or Divorced, (write the word) Single6a If married, widowed, or divorced,  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) April 7, 1928

7 AGE

Years

Months

Days

IF LESS than  
1 day...hrs.  
or...min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work... W(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore(State or country) MD10 NAME OF FATHER Joseph Kusyk11 BIRTHPLACE OF FATHER (city or town) Illigian

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14

Informant  
(Address) 229 S Washington

R 1928

15

JAMES JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1928

19

17

I HEREBY CERTIFY That I attended deceased from

April 7, 1928 to April 7, 1928

that I last saw him alive on

and that death occurred, on the date stated above, at 10:15 am

The CAUSE OF DEATH\* was as follows:

Cholelithiasis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death?..... Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Jones(Address) 229 S Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy RosaryApril 9, 1928

20 UNDERTAKER

ADDRESS

401 S Chester St John M. Weber

very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32598

## CERTIFICATE OF DEATH.

X 84 E 32598

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE; (No. 7-9

ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Duvall

(a) RESIDENCE No. 326 Morrison, Raleigh, N.C. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maude Duvall

6 DATE OF BIRTH (month, day, and year) 4/8/28

7 AGE 40 Years 5 Months 21 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

10 NAME OF FATHER John Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Emma Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant JOHNS HOPKINS HOSPITAL (Address) Room 200

15 Filed 8-19-28 G. HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/28 19

17

I HEREBY CERTIFY, That I attended deceased from 4/4, 1928, to 4/8, 1928, that I last saw him alive on 4/8, 1928,

and that death occurred, on the date stated above, at 3:20 A. M.

The CAUSE OF DEATH was as follows:

Brain Tumor - Hypophyseal adenoma benign

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/7/28

Was there an autopsy? No

What test confirmed diagnosis? Clinical &amp; Operative

(Signed) George G. Finney, M. D.

April 8, 1928 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL (City or town) DATE OF BURIAL

Sunderland Md. 4-11-28

20 UNDERTAKER

Frank J. Co

ADDRESS

Wash. DC

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. **3540 Frederick Ave**)2. FULL NAME **Ella J. Guertler**(a) RESIDENCE No. **3540 Frederick Ave**

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST. **WARD**

WARD

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO.

**74 E 32599**

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

**Female**

4 COLOR OR RACE

**White**5 Single, Married, Widowed,  
or Divorced, (write the word)  
**Widow**

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of**Albert E. Guertler**6 DATE OF BIRTH (month, day, and year) **Aug. 27, 1853**

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.**75**

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work **Housewife**(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) **Baltimore, Md.**  
(State or country)10 NAME OF FATHER **John Caton**11 BIRTHPLACE OF FATHER (city or town)  
(State or country) **Ireland**12 MAIDEN NAME OF MOTHER **Not Known**13 BIRTHPLACE OF MOTHER (city or town) **Ireland**  
(State or country)

14

Informant **Mr. Thos. McLaughlin,**  
(Address) **613 E. 30th Street,**

15

PR 8 - 1928 HAMMOND JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **4/4** 19 **28**

17

I HEREBY CERTIFY, That I attended deceased from  
**Jan 13**, 19 **28**, to **Apr 4**, 19 **28**that I last saw her alive on **Apr 4**, 19 **28**  
and that death occurred, on the date stated above, at **3:40 P** m.

The CAUSE OF DEATH\* was as follows:

**Cerebral apoplexy**(duration) yrs. **2 1/2** mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? **✓**Did an operation precede death? **no** Date of **✓**Was there an autopsy? **no**What test confirmed diagnosis? **✓**(Signed) **J. W. Gaddess****4/6/28** (Address) **321 - E - 25th St.** M. D.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL **New Cathedral**

DATE OF BURIAL

**Apr 3 - 28**

20 UNDERTAKER

ADDRESS

**311****Spaulding Ave**

32600

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32600

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Square Hospital*  
 CITY OF BALTIMORE: (No. *Calhoun + Fayette* ST. *21-31* WARD)

2-FULL NAME *Charles H. Leer*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *503 N. Hamburg*  
 (Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred *life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 9, 1862*

7 AGE Years *66* Months *1* Days *27* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md*  
 (State or country)

10 NAME OF FATHER *Herman Leer*

11 BIRTHPLACE OF FATHER (city or town)  
 (State or country) *Germany*

12 MAIDEN NAME OF *Wesselman*

13 BIRTHPLACE OF MOTHER (city or town)  
 (State or country) *Germany*

14 Informant *Mary Leer*  
 (Address) *503 N. Hamburg St*

15 Filed *1928* *C. HAMPTON* M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 6, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 4, 1928*, to *April 6, 1928*, that I last saw him alive on *April 5, 1928*, and that death occurred, on the date stated above, at *2:45 A* m.

The CAUSE OF DEATH\* was as follows:

*Chronic diffuse nephritis with uremia*

(duration) yrs. mos. ds.

CONTRIBUTORY *Terminal pneumonia*  
 (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted  
 if not at place of death? *Home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Elizabeth B. Sherman* M. D.

19 (Address) *Franklin Square Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL  
 MOVAL

*Baltimore Cem - April 9, 1928*

UNDERTAKER *Mrs John H. Duffels* ADDRESS *801 N. Fayette*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32601

## CERTIFICATE OF DEATH.

51 E 32601

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 McCallum ST. 7-10 WARD)

2-FULL NAME Joseph Tudor

(a) RESIDENCE NO. 2206 McCallum ST., WARD

(Usual place of abode) Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? Life yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 23, 1920

7 AGE Years 8 Months 14 Days 13 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

10 NAME OF FATHER James C. Tudor

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophie Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant James C. Tudor (Address) 2206 McCallum St.

15 Filed APR 8 - 1928 HALL JONES, D. Registrar Rick

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-28

17 I HEREBY CERTIFY, That I attended deceased from 4-4-28 to 4-6-28, that I last saw him alive on 4-6-28 and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH\* as follows:  
Acute Myocardial Infarction  
acute Endocarditis

CONTRIBUTOR (Secondary) Acute Myocardial Infarction (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in situ

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. H. Jones, M.D. 19 28 (Address) 500 N. Ball St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer Cem. DATE OF BURIAL April 9, 1928

20 UNDERTAKER Wm. E. Miller & Son ADDRESS 2034 Jaffa St.



E 32602

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32602

## CERTIFICATE OF DEATH. 109-002

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 336 S Monroe ST., 20-28 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J. Beale

(a) RESIDENCE NO. 336 S Monroe

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 1925

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

3

1

16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Frank Beale

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cuma

12 MAIDEN NAME OF MOTHER

Margaret Beale

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Mr. Frank Beale

336 S Monroe St

15

Filed

G. H. HARRIS, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1928, to April 5, 1928.

that I last saw him alive on April 5, 1928

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Endocarditis

CONTRIBUTORY (Secondary)

(duration)

1 chronic mos

(duration)

yrs. mos. one week

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

, 19

(Address)

8003 Garrison

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Port View

April 9 1928

20 UNDERTAKER

ADDRESS

John J. Brown &amp; Son

York

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32603

## CERTIFICATE OF DEATH.

E 32603

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Bulto general Hosp.* *9-47* WARD)2-FULL NAME *Michael L. Elbey*(a) RESIDENCE NO. *752 Melv. Ave.*

(Usual place of abode)

Length of residence in city or town where death occurred *28* yrs. *10* mos. *17* ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*W.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*5a If married, widowed, or divorced  
HUSBAND of *Barbara A. Elbey*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 19-1899*

7 AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.*28* yrs*10**17*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balt., Md*  
(State or country)10 NAME OF FATHER *Samuel Evans*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Bermuda*12 MAIDEN NAME OF MOTHER *Ma. G. Rhodes*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Balt., Md*

14

Informant  
(Address)*Carl David Elbey*  
*752 Melv. Ave.*

15

File

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*3 (21)*, 1928, to *April 6*, 1928.that I last saw him alive on *April 6*, 1928.and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH\* was as follows:

*Elapsion (auto-partum)*

(duration)

yrs.

mos

*24* hrsCONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death? *home*Did an operation precede death? *Yes* Date of *4/5/28*Was there an autopsy? *-*What test confirmed diagnosis? *Clinical symptoms*(Signed) *Arthur H. Jones*

M. D.

4/6, 1928 (Address) *817 Park Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

20 UNDERTAKER

*Woodlawn Ch*  
*J. J. Jones*

DATE OF BURIAL

ADDRESS

*Apr 10 1928*  
*701a*

E 32604

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *521 N Decker Ave* ST.,WARD *11*)2-FULL NAME *Gertrude Renshaw*(a) RESIDENCE NO. *521 N Decker* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *1* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. *11-002 E 32604*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed,  
or Divorced, (write the word) *Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Mar 29-1927*

7 AGE

Years *1*

Months

Days *8*If LESS than  
1 day, .... hrs.  
or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work *None*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *Balto*10 NAME OF FATHER *Alvin S. Renshaw*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Balto*12 MAIDEN NAME OF MOTHER *Ellie Beal*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Bermond*

14

Informant *Alvin S. Renshaw*(Address) *521 N Decker Ave*

15

Filed *8*

1928

HART

JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-7-28*

17

I HEREBY CERTIFY, That I attended deceased from

*4-1-28*, 19*28*, to *4-7-28*, 19*28*.that I last saw her alive on *4-7-28*and that death occurred, on the date stated above, at *4-7-28* m.

The CAUSE OF DEATH\* was as follows:

*Influenza*CONTRIBUTORY (Secondary) *Influenza Meningitis*  
(duration) *7* mos. *7* ds.18 Where was disease contracted  
if not at place of death? *unknown*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *pending*(Signed) *J. M. Renshaw*, M. D., 19*28* (Address) *800 N. Calver St. Bk 4*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Bak Lawn Cem*

DATE OF BURIAL

*Apr 9 1928*

20 UNDERTAKER

*John Ullrich*

ADDRESS

*2008 Orleans*

E 32605

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32605

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1615 Fulton*)ST. *16-37*

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John J. Kelly*(a) RESIDENCE NO. *1615 Fulton*

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Married*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Katherine Kelly*

6 DATE OF BIRTH (month, day, and year)

*Dec 18, 1856*

7 AGE

Years

Months

Days

LESS than

1 day. hrs.

or min.

*71 3 9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employee)

(c) Name of employer

*Retired*

9 BIRTHPLACE (city or town) (State or country)

*Texas Tex*

10 NAME OF FATHER

*Michael Kelly*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Margaret Kelly*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

14

Informant (Address)

*The Jones 1615 Fulton St*

15

File 1928

*G. HAMPTON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mon 1*, 1927, to *Feb 6*, 1928.that I last saw him alive on *Apr 4*, 1928.and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*(duration) *1* yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

*O. H. Duwall* 47, 1928 (Address) *1817 N. Fulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Catholic Cem. Apr 7, 1928*  
*Margaret S. Taylor*



32606

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 N. Eden

2-FULL NAME Michael Hebrank

(a) RESIDENCE NO. 910 N. Eden  
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. -- mos. -- ds.

ST. 10-14 WARD

REGISTERED NO. 31 E 32606

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary S. Klump

6 DATE OF BIRTH (month, day, and year) April 13, 1856

7 AGE Years 71 Months 11 Days 24 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer Pennsylvania Railroad

9 BIRTHPLACE (city or town) Lancaster  
(State or country) Pennsylvania

10 NAME OF FATHER Henry Hebrank

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Traeg

13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Mrs. Mary S. Hebrank  
(Address) 910 N. Eden Street15 1928 C. HAMPSON JONES, M. D.  
Filed 19 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1928

17 HEREBY CERTIFY, That I attended deceased from March 10th 1928 to April 7th 1928

that I last saw him alive on April 5th 1928 and that death occurred, on the date stated above, at 4.00 p.m.

The CAUSE OF DEATH\* was as follows:

Nervous Exhaustion  
Caused by a heart  
(duration) yrs. mos. ds.CONTRIBUTORY (Secondary) 24 hrs. 0 mos. 0 ds.  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Jones M. D.  
19 Address 1027. Claymont

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Cemetery 4/10 1928

20 UNDERTAKER Henry W. Mears &amp; Son 805 N. Calver

E 32607

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32607

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1021 Jenkins* ST. *11-24* WARD)2. FULL NAME *William Carter*(a) RESIDENCE NO. *1021 Jenkins* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred *life* mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male* *col**single*

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 8-1927*

7 AGE

Years

Months

Days

8 LESS than

1 day, hrs.

or min.

*6* *5* *28*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on *Apr 5 1928* to *Apr 6 1928*and that death occurred, on the date stated above, at *8 PM* m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4/2 1928 (Address)

*B. N. Walker* M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

APR 9 1928

BALTIMORE

*Wm. Carter**4/8-1928*  
*9/6*  
*Pa. Ave*

21235-2

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

REGISTERED NO. 32608

CITY OF BALTIMORE: (No.

ST. 7-9 WARD)

2-FULL NAME

Sophie Mason

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Sparks Rd -

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

2 weeks

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

5-7-26

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

92

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind -

10 NAME OF FATHER

Ernest Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind -

12 MAIDEN NAME OF MOTHER

Mamie Fair

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind -

14

Informant (Address)

Records - HOSPITAL

15

Filled

19

C. HANCOCK JONES, M.D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 7 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar - 22 1928 to April 7 1928.

that I last saw her alive on April 7 1928 and that death occurred, on the date stated above, at 12:10 p.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis pneumonia left upper lobe

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Tuberculosis meningitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? T. b. bacilli in sputum + spinal fluid.

(Signed) I. R. Grewing M.D.

4-7-28 (Address) Johns Hopkins Hop.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Family Burial Ground Co Inc

4/9-1928

UNDERTAKER

ADDRESS 916

Daniel Carter

Bo ae

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32609

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1221 Wilkes*St. *17* Ward *24*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William Wilson*(a) RESIDENCE NO. *1221 Wilkes*

(Usual place of abode)

St. *17* WardLength of residence in city or town where death occurred *4* yrs. *4* mos. *4* ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**wh**married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Laborer*

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

*William Wilson*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MARDEN NAME OF MOTHER

*James Hall*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)*Agnes Wilson*  
*1221 Wilkes*

15 Filed

1928

C. 19

HARRISON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 5 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*April 4 1928* to *April 5 1928*that I last saw him alive on *April 5 1928*and that death occurred, on the date stated above, at *400* m.

The CAUSE OF DEATH\* was as follows:

*Apoplexy*

CONTRIBUTORY

(Secondary)

*Interstia*

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Chemical*(Signed) *Chas J. Clement* M. D.*Apr 9 1928* (Address) *1501 McMillan*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Laurel*

20 UNDERTAKER

*Samuel Carter**4/9 1928*ADDRESS *916**Ba*

OF DEATH IN BALTIMORE. See instructions on back of certificates. very important.

PR 3



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32610  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH

74002  
E 32610  
REGISTERED NO.City of BALTIMORE: (No. 1601 Bolton Street 14-70 Ward)

2-FULL NAME

Anna Josephine Pearre

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1601 Bolton

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofAubrey Pearre

6 DATE OF BIRTH (month, day, and year)

Jan. 11, 1844

7 AGE

Years

84

Months

2

Days

27IF LESS than  
1 day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None - housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Frederick

(State or country)

Maryland

10 NAME OF FATHER

John Sifford

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Franklin Co., Pa.

12 MAIDEN NAME OF MOTHER

Mary Lorentz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14

Informant  
(Address)Aubrey Pearre Jr.  
1063 Cedar St. Balto., Md.

15 Filed

1928

16

HARRISON JONES, M. D.

Registrar

Per

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

April 7, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 31, 1928, to April 7, 1928that I last saw her alive on April 6, 1928and that death occurred, on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH\* was as follows:

Thrombosis cerebral vessels.  
(Terminal attack)(duration) 37 yrs. — mos. — ds.CONTRIBUTORY  
(Secondary)Repeated cerebral thromboses(duration) 22 yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Van Dine, M. D.47. 1928 (Address) 1575 Park Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St Thomas Garrison CemeteryApril 9, 1928

20 UNDERTAKER

Henry Jenkins SonsADDRESS  
McEldrich  
Richards St.OF DEATH in plain text. See instructions on back of certificates.  
very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32611

74-001 E 32611

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 Brint ST. 14-70 WARD)2-FULL NAME Matter J. Chapman(a) RESIDENCE No. 1905 Brint

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds.ST. 14-70 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE Colored5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan, 5-1872

7 AGE

Years 56Months 3

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md10 NAME OF FATHER Thomas J. Chapman11 BIRTHPLACE OF FATHER (city or town) (State or country) Md12 MAIDEN NAME OF MOTHER Stukowon13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14

Informant (Address) Louise Chapman

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-1928

17

I HEREBY CERTIFY, That I attended deceased from 4-4-1928 to 4-5-1928 that I last saw him alive on 4-5-28, 19and that death occurred, on the date stated above, at 10:27 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage(duration) yrs. mos. 1 dayCONTRIBUTORY (Secondary) arteriosclerosis18 Where was disease contracted if not at place of death? hypertension (duration) yrs. mos. ds.Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? History & physical (Signed) Ernest C. Milton M.D.19 (Address) 2001 Penna. Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32612

## CERTIFICATE OF DEATH.

9 E 32612  
REGISTERED NO. 2

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2407 Mac St* ST. *12-51* WARD)2-FULL NAME *Milton Robinson*(a) RESIDENCE NO. *2407 Mac St* ST., ..... WARD .....  
(Usual place of abode)Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Brown* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug - 8 - 1927*7 AGE Years Months Days If LESS than 1 day, hrs or min. *7* *28*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Eppie Robinson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Miss Jones*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Eppie Robinson*  
(Address) *12907 Mac St*APR 3 1928  
Filed 19 *1928* Registrar *JONES, M.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 6* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *April 2nd*, 1928, to *April 6*, 1928,that I last saw him alive on *April 6*, 1928,and that death occurred, on the date stated above, at *1 P* m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia*CONTRIBUTORY (Secondary) *Whooping Cough*  
(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *Physical Exam*(Signed) *J. H. Hall*, M. D.19 (Address) *4266 23rd St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

*M. Robinson* *4 1 28*UNDERTAKER *Samuel H. H. H. H.*ADDRESS *M. Robinson*

Pascucci

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32613

## CERTIFICATE OF DEATH.

74-001

E 32613

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4823 Park Heights Ave. ST. 27-56 WARD)

## 2. FULL NAME

Theodor Pascucci

## (a) RESIDENCE

4823 Park Heights Ave. ST. 27-56 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State) yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed,

or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Edna Pascucci

## 6 DATE OF BIRTH (month, day, and year)

Feb 15 1865

## 7 AGE

63

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Retired

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Italy

## 10 NAME OF FATHER

John Pascucci

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Italy

## 12 MAIDEN NAME OF MOTHER

Edna Tascelli

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Italy

## 14

Informant  
(Address)John Pascucci  
4823 Park Heights Ave.

## 15

Filed

19

C. H. HARRIS, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 5 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

March 26, 1928, to April 5, 1928

that I last saw him alive on April 5, 1928

and that death occurred, on the date stated above, at 1030 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 11 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

John D. Ruben, M. D.

19 (Address) 4754 Park Heights Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Holy Redeemer Church April 9 1928

## UNDERTAKER

ADDRESS

George - J. Ruttini 1725 Hayford Ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32614

## CERTIFICATE OF DEATH.

74-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 9 Spring

ST. 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME John Mitchell

(a) RESIDENCE NO. 1618 9 Spring  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Mitchell

6 DATE OF BIRTH (month, day, and year) Nov 28 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

10 NAME OF FATHER John Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) German

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14

Informant Louise Mitchell

(Address) 1618 N Spring St

15

APR 9 1928

HARRISON JONES, M. D.

Reg.

George J. Ruth

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 - 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 6 - 1928, to Apr. 7 - 1928,

that I last saw him alive on Apr. 6 - 1928,

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH\* was as follows:

Paralysis Hemorrhage of brain

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Trenby, M. D.

4/9/1928 Address 1223 N. Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Church

Apr 10 1928

20 UNDERTAKER

ADDRESS

1735 Hayford Ave

## E 32615 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32615

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 E. Federal St. 8-17 WARD)

## 2-FULL NAME

Jacob C. Rensel

## (a) RESIDENCE No.

1510 E. Federal St.

(Usual place of abode)

Length of residence in city or town where death occurred

60

yrs.

mos.

How long in U. S., if of foreign birth?

60

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
or) WIFE of

Elizabeth Rensel

## 6 DATE OF BIRTH (month, day, and year)

Nov 30 1845

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

82

4

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Clerk.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Nundack CO

9 BIRTHPLACE (city or town)  
(State or country)

Germany

## 10 NAME OF FATHER

Jacob Rensel

## 11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

## 12 MAIDEN NAME OF MOTHER

Christina Rensel

## 13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

## 14

Informant  
(Address)Mrs. Elizabeth Rensel  
1510 E. Federal St.

## 15

Filed

19

C. H. HANCOCK, M.D.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr 5 1928

## 17

I HEREBY CERTIFY, That I attended deceased from  
Oct 15, 1927, to Apr 5, 1928,

that I last saw him alive on

Apr 5, 1928

and that death occurred, on the date stated above, at

3 p. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach

(duration)

yrs. 10

mos.

ds.

CONTRIBUTORY  
(Secondary)

Carcinoma of Stomach

(duration)

yrs.

mos.

ds. 3

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical, Laboratory, Ray

(Signed)

W. A. Thomas, M. D.

Date

Apr 7, 1928 (Address) 1228 New Line

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Baltimore County

Apr 9 1928

George J. Ruth

1735 Hayford Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32616

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 32616

CITY OF BALTIMORE: (No. *520 E. Eager*)

2-FULL NAME *Edward F. Mulgrew*

(a) RESIDENCE NO. *520 E. Eager*  
(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

ST. *10-15* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary J. Mulgrew nee Murphy*

6 DATE OF BIRTH (month, day, and year) *Oct. 12, 1865*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*61 5 25*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Letter in*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Post Office*  
(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md*  
(State or country)

10 NAME OF FATHER *Francis Mulgrew*

11 BIRTHPLACE OF FATHER (city or town) *Ireland*  
(State or country)

12 MAIDEN NAME OF MOTHER *Sarah Short*

13 BIRTHPLACE OF MOTHER (city or town) *Scotland*  
(State or country)

14 Informant *Mary J. Mulgrew nee Murphy*  
(Address) *520 E. Eager St.*

15 Filed *1928*  
*C. HAMPSHIRE JONES, M.D.* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 7, 1928*

17 I HEREBY CERTIFY, That I attended deceased from *March 29, 1928* to *April 7, 1928*, that I last saw him alive on *April 7, 1928*

and that death occurred, on the date stated above, at *12:15 p.m.*  
The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Induratio + myocarditis*  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ☒

Did an operation precede death? *No* Date of ☒

Was there an autopsy? *No*

What test confirmed diagnosis? *Physical findings & history*  
(Signed) *J. Neil MacFarlane, M.D.*

19 (Address) *16911 Hayford Rd.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

*New Cathedral Cemetery April 11, 1928*

20 UNDERTAKER ADDRESS

*Emmet W. Conklin 824 E. Eager St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32617

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST 4-25 WARD WARD)2-FULL NAME Minnie Lamartina(a) RESIDENCE NO. 128 N. Pearl

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25, 19267 AGE Years 1 Months 5 Days 12 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER Charles Lamartina11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.12 MAIDEN NAME OF MOTHER Frank Purdy13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.14 Informant (Address) Charles Lamartina15 Filed 1928 INDEXED JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 19 2817 I HEREBY CERTIFY, That I attended deceased from March 30, 19 28, to April 7, 19 28.that I last saw her alive on April 7, 19 28, and that death occurred, on the date stated above, at 11 55 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. mos. 9 ds.CONTRIBUTORY Acute heart failure (Secondary)(duration) yrs. mos. 3 hrs.18 Where was disease contracted if not at place of death? 128 N. Pearl StDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) J. J. Lusby M. D.19 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Edmund W. Bonk 924 E. Eager



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32618

## CERTIFICATE OF DEATH.

185 E 32618  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Leonard Airey.(a) RESIDENCE NO. 411 E. Hamburg St.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 1 ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male.White.Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

---

6 DATE OF BIRTH (month, day, and year)

April 5, 1923

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.501

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

10 NAME OF FATHER

Olla Airey.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Cambridge, Md.12 MAIDEN NAME OF MOTHER Mary E. Breeden.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant Mary E. Airey. (mother)  
(Address) 411 E. Hamburg St.

15

Filed..... 19 C. H. Jones

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 6, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Internal Injuries  
Accidental fall from a 2nd story window

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) C. H. Jones M. D.  
(Coroner)4/7, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?  
411 E. Hamburg St. April 6, 1928.

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Western B. & M. April 9, 1928

20 UNDERTAKER

ADDRESS

D. I. Evans 38 E. Fort Ave

Very Important. See instructions on back of certificate.

E 32619

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32619

## CERTIFICATE OF DEATH.

161-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital 4-25*)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Florie*(a) RESIDENCE NO. *6 1/4 Saratoga*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *3/26/28*

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balt.*10 NAME OF FATHER *Joseph Forte*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Helen Forte*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant  
(Address)

## 15

Filed

19

J. H. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/26/28* 19

## 17

I HEREBY CERTIFY, That I attended deceased from

*3/24/28*, 19, to *3/26/28*, 19,that I last saw him alive on *3/26/28*, 19and that death occurred, on the date stated above, at *9P* m.

The CAUSE OF DEATH\* was as follows:

*Premature still birth*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *H. Lawrence Falmes*, M. D., 19 (Address) *St Joseph Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

19

## UNDERTAKER

ADDRESS

Commissioner Health

APR 2 - 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32620

## CERTIFICATE OF DEATH.

90 E 32620

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6021 Stanton Ave ST. MT. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine C. Hook(a) RESIDENCE NO. 6021 Stanton Ave ST. MT. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

(or) WIFE of

Charles G. Hook6 DATE OF BIRTH (month, day, and year) June 18647 AGE Years 63 Months 10 Days 03 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)10 NAME OF FATHER Thomas Stanton11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Noran13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant Charles G. Hook (Address) 6021 Stanton Ave.15 Filed 9-19-28 C. HANCOCK JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 19 2817 I HEREBY CERTIFY, That I attended deceased from 4/8 19 28 to 4/8 19 28that I last saw him alive on 7/4 19 28and that death occurred, on the date stated above, at 3.00 a.m.

The CAUSE OF DEATH\* was as follows:

MyocarditisCONTRIBUTORY (Secondary) Coronary Sclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Henry F. O'Leary M. D. (Address) 1164 North 1st St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Imperial Ridge April 10 1928  
Martin P. Lyons & Sons 1827 N. North





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32622

## CERTIFICATE OF DEATH.

185 E 32622

## 1-PLACE OF DEATH

City of BALTIMORE: (City or town)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

16

Filed

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, that I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured Skull

CONTRIBUTOR (Secondary)

Fall off Bridge (Accident)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificate.

16

Filed

Reg.

Registrar

20

UNDERTAKER

Mr. Kate R. Williams

Schroeder &amp; Co.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32623

## CERTIFICATE OF DEATH.

57 E 32623

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 112 St. Montford Ave-10 Ward)2-FULL NAME Beckie Friedman(a) RESIDENCE NO. 112 St. Montford Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) maiden

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofAbraham Friedman6 DATE OF BIRTH (month, day, and year) Jan 1908

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.55

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

Jack Lewis1439 E. Baltimore St.

15

Filed

1928

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## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8/28 19217 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.)and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Diabetes Mellitis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) John J. O'Brien

(Coroner)

M. D.

4/9/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Hebrew Mt. Cemetery 4/9/28

20 UNDERTAKED

ADDRESS

Jack Lewis 1439 E. Baltimore St.

very important. See instructions on back of certificate.

E 32624

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32624

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *411 Polson* ST. *24-33* WARD)2-FULL NAME *Harry Luther Wrightson*(a) RESIDENCE NO. *411 Polson*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*5a If married, widowed, or divorced HUSBAND of (or) *Esther Landon*6 DATE OF BIRTH (month, day, and year) *Mar. 2<sup>nd</sup> 1904*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*24**1**3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Elevator Operator*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *City*10 NAME OF FATHER *Chas. W. Wrightson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Pa.*12 MAIDEN NAME OF MOTHER *Eva Butler*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *City*

14

Informant (Address) *Mrs. Eva Butler*

APR 9 - 1928

Filed

OUT

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 5<sup>th</sup> 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 1<sup>st</sup> 1928* to *April 5<sup>th</sup> 1928*; that I last saw *him* alive on *April 4<sup>th</sup> 1928*; and that death occurred, on the date stated above, at *4:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*

CONTRIBUTORY (Secondary)

*Cholelithiasis*18 Where was disease contracted if not at place of death? *Yes*

Did an operation precede death?

Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John A. Scheunich*

M. D.

, 19

(Address) *1337 S. Charles St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Calver Hill Cemetery**4/9 1928*

UNDERTAKER

ADDRESS

*E. J. Hanning, 1468 Battery Ave.*

E 32625

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Dr. Edw. Norris

E 32625

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1518 Battery Ave.* *24-34* ST. WARD)2-FULL NAME *Mary Margaret Mattingly*(a) RESIDENCE NO. *1518 Battery*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*W.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Thomas D.*6 DATE OF BIRTH (month, day, and year) *Nov. 23, 1843*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*84**4**13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*City*10 NAME OF FATHER *Geo. Thierbach*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*12 MAIDEN NAME OF MOTHER *Cuddy*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*N.Y.*

14

Informant (Address)

*Mrs. Fowler 1518 Battery Ave.*

15

Filed

PR 3-1923

Registrar

## MEDICAL CERTIFICATE OF

16 DATE OF DEATH (month, day, and year) *April 6, 1928**1928*

17

I HEREBY CERTIFY, That I attended deceased from

*February 23, 1928, to April 6, 1928.*that I last saw him alive on *April 5, 1928*and that death occurred, on the date stated above, at *4.30* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*(duration) *don't know* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical & laboratory*(Signed) *J. Edward Norris*, M. D.Address *107 East West St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Woodlawn Cemetery**4/9/1928*

20 UNDERTAKER

ADDRESS

*E. J. Fanning, Inc. - 1420 Battery Ave.*





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32627

## CERTIFICATE OF DEATH

129 E 32627

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 325 S. Chapel St. 2 Ward)2-FULL NAME Christian Weber

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 325 S. Chapel St. 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Weber6 DATE OF BIRTH (month, day, and year) April 26 18597 AGE Years 68 Months 11 Days 12 IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer for P.R.R.  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)10 NAME OF FATHER Christian Weber11 BIRTHPLACE OF FATHER (City or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Don't Know.13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Annie Weber, (Wife)  
(Address) 325 S. Chapel St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 19 2817 I HEREBY CERTIFY, That I attended deceased from April 7 19 28that I last saw him alive on April 7 19 28and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY Chronic Bronchitis  
(Secondary)(duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? ✓(Signed) Jacob L. Lehman, M. D.4-19-1928 (Address) 30 S. B'way

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery April 12 19 2820 UNDERTAKER Lilly & Zeller Inc. ADDRESS 403 S. Wolfe St.

very important. See instructions on back of certificate.

APR 9 1928

G. HARRISON JOHNS, M. D.  
Registrar







## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32630

## CERTIFICATE OF DEATH.

100-001

E 32630

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 11-24 Ward)

2-FULL NAME Morris Wingate Johnson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 1103 Bolton St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26/27

7 AGE Years 1 Months 1 Days 8 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md. (State or country)

10 NAME OF FATHER Daniel Johnson

11 BIRTHPLACE OF FATHER (city or town) N.C. (State or country)

12 MAIDEN NAME OF MOTHER Vivian Williams

13 BIRTHPLACE OF MOTHER (city or town) N.C. (State or country)

14 Informant Mattie Wingate

(Address) 1103 Bolton St

very important. See instructions on back of certificate.

APR 9 - 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, autopsy or inquiry.)

inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia  
Otitis Media

Ricketts (Autopsy at Hopkins)  
(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(duration) yrs. mos. ds.

(Coroner)

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

18 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

19 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32631  
PLACE OF DEATH9 E 32631  
REGISTERED NO.City of BALTIMORE: (No. Hopkins Hospital 6-9 Ward)2-FULL NAME William Finch(a) RESIDENCE NO. 237 N. Dallas

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred 2 yrs. 7 mos. 1 ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race colored 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept 6/24

7 AGE Years Months Days IF LESS than  
3 7 1 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work..... none(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country)

Md.

10 NAME OF FATHER

Herman Finch

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Pattie Short

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

N.C.

14

Informant Father  
(Address)

15

File 1928 C. H. FINCH, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 7/2817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.)find that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. ds.  
CONTRIBUTORY Pertussis  
(Secondary)

(Signed) J. A. Brown

(Coroner)

M. D.

4/9/28 (Address) 508 E. North Ave\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs.,.....mos.,.....ds. State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVALAsbury cemetery April 10, 28

20 UNDERTAKER

Edward Bryan orleans st

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32632

## CERTIFICATE OF DEATH.

129

E 32632

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hotel Atholmont*)

## 2-FULL NAME

(a) RESIDENCE. (No. *Hotel Atholmont*)

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced, HUSBAND or (or) WIFE of

*Married*

6 DATE OF BIRTH (month, day, and year)

*April 17, 1855*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*73**-**6*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Virginia*

10 NAME OF FATHER

*James Child*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Virginia*

12 MAIDEN NAME OF MOTHER

*Elizabeth Human*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Virginia*

PARENTS

14

Informant (Address)

15

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 7th 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*October 1927 to April 7th 1928*that I last saw her alive on *April 7th 1928*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Chronic Endocarditis, Cardiac Hypertrophy & Decompensation*

(duration)

2 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*Hypertension*

(duration)

2 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Edward D. Leach* M. D.1928 (Address) *511 Euton Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Christiansburg Va**April 9 1928**1632 Hollins*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32633

## CERTIFICATE OF DEATH.

31 E 32633

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1038 N. Franklin St. 8-26 Ward)2-FULL NAME Alice M. Klaus(a) RESIDENCE NO. 1038 N. Franklin St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 8 mos. 5 ds. (If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced. (write the word) Mar5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. R. Klaus6 DATE OF BIRTH (month, day, and year) Aug. 2 / 18887 AGE 39 Years Months 8 Days 5 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Balto (State or country)10 NAME OF FATHER Henry P. Rapp11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)12 MAIDEN NAME OF MOTHER Mary C. McCarthy13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)14 Informant A. R. Klaus (Address) 1038 Franklin15 Filed 1928 C. HANCOCK JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 / 28 1917 I HEREBY CERTIFY, That I attended deceased from Mar 15 28, 1928, to Aug 7, 1928, that I last saw him alive on Aug 6, 1928, and that death occurred, on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary TuberculosisCONTRIBUTORY (duration) 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. Pulmonary Aneurysm (Secondary)(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

18 Where was disease contracted

If not at place of death? NoDid an operation precede death? No Date NoWas there an autopsy? NoWhat test confirmed diagnosis? T.P.T.(Signed) J. T. P., M. D. (Address) 939 N. Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral4-10 1928

20 UNDERTAKER

ADDRESS

Henry B. Cummings 1136 Poplar St

very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32634

## CERTIFICATE OF DEATH.

89 E 32634

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Oakdale Rd. ST. 27-53 WARD 1)2-FULL NAME Grace Griffiss Jacobsen(a) RESIDENCE NO. 309 Oakdale Rd. ST. 27-53 WARD Resident

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 30 ds.How long in U. S., if of foreign birth? 63 yrs. 2 mos. 30 ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced, HUSBAND (or) WIFE Alfred W. Jacobsen6 DATE OF BIRTH (month, day, and year) Jan-8-1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min. 63 2 30

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland10 NAME OF FATHER Thos. J. Griffiss11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland12 MAIDEN NAME OF MOTHER Emma Witzel13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

PARENTS

14 Informant (Address) Alfred W. Jacobsen - (husband)  
Resident - City -

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1928

17

I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1927 to April 7, 1928.that I last saw her alive on April 7, 1928and that death occurred, on the date stated above, at 2-50 P. m.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis.  
Angina Pectoris

CONTRIBUTORY (Secondary)

(duration) 4 yrs. 1 mos. 1 ds.General Arterio Sclerosis(duration) 3 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? —Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Physical signs -(Signed) W. Gibson Fortin M. D.4/8, 1928 (Address) 422 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Gravelly Hill CemeteryDATE OF BURIAL Apr 9/192820 UNDERTAKER Stewart HowenloADDRESS Balto.

APR 9 - 1928

JONES, M. D.  
Registrar

# HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32635

## CERTIFICATE OF DEATH.

101-001 E 32635

1-PLACE OF DEATH

Sydenham Hospital,

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

17-50 WARD)

2-FULL NAME

C. Percy Kemp.

(a) RESIDENCE No.

2507 N. Calvert

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 45 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Blanche F. Kemp

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

59

Years

Months

Days

If LESS than 1 day. hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Zachariah

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

C. Percy Kemp 2507 N. Calvert St

15

Filed

G. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-28 1928

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1928, to April 8, 1928,

that I last saw him alive on April 8, 1928,

and that death occurred, on the date stated above, at 7:10 P. M.

The CAUSE OF DEATH\* was as follows:

Daniel Erysipelas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Lober pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Sachman, M. D.

(Address) Sydenham Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOYAL

Stevensville Md

UNDERTAKER

W. B. Cook

DATE OF BURIAL

4/10 1928

ADDRESS

502 E North

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32636

## CERTIFICATE OF DEATH

14-001 E 32636

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1417 N. Bruce St. 15-21 Ward)

2-FULL NAME Benj Crawford

(a) RESIDENCE NO. 1417 N. Bruce St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male Col married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Florence Crawford

6 DATE OF BIRTH (month, day, and year)

1876

7 AGE Years Months Days IF LESS than 1 day hrs. or min..

57

02

2

—

—

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Howard C. Md.

(State or country)

10 NAME OF FATHER

John Crawford

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Howard C. Md.

12 MAIDEN NAME OF MOTHER

Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Howard C. Md.

14

Informant (Address)

Florence Crawford

15 Filed

APR 9 - 1928

HAMPDEN COUNTY, Md. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5, 1928

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1928, to Apr. 5, 1928,

that I last saw him alive on Apr. 5, 1928,

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

B. N. Hatcher M. D.

(Address) 1220 Pa Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt. Auburn Cemetery

April 8, 1928

20 UNDERTAKER

Thomas C. Nelson

ADDRESS

1303 Priestman St

very important. See instructions on back of certificate.

E 32637

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32637

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

100-001

REGISTERED NO.

CITY OF BALTIMORE: (No. 15-21 ST. 5-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Way

(a) RESIDENCE NO. 1821 Caranough ST. 5-21 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

### MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Single

16 DATE OF DEATH (month, day, and year) April 6 19 28

6 If married, widowed, or divorced HUSBAND of (or) WIFE of                     

17 I HEREBY CERTIFY, That I attended deceased from March 18, 19 28, to April 6, 19 28, that I last saw her alive on April 6, 19 28, and that death occurred, on the date stated above, at 5:40 a. m.

6 DATE OF BIRTH (month, day, and year) 6-24-26

The CAUSE OF DEATH\* was as follows: Bronchopneumonia, left lung.

7 AGE Years 1 Months 9 Days 12 If LESS than 1 day. hrs. or min.

### 8 OCCUPATION OF DECEASED

CONTRIBUTORY (Secondary) Severe rheumatism (duration) yrs. mos. ds. 22

(a) Trade, profession or particular kind of work infant  
(b) General nature of industry, business, or establishment in which employed (or employer)                       
(c) Name of employer                     

9 BIRTHPLACE (city or town) (State or country)                     

18 Where was disease contracted if not at place of death? Home

10 NAME OF FATHER Eli Way

Did an operation precede death? No Date of                     

11 BIRTHPLACE OF FATHER (city or town) (State or country)                     

Was there an autopsy? No

12 MAIDEN NAME OF MOTHER Matilda Woodman

What test confirmed diagnosis? Autopsy  
(Signed) J. B. Smith M. D.  
April 6, 19 28 (Address) Johns Hopkins Hospital

13 BIRTHPLACE OF MOTHER (city or town) (State or country)                     

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant                      HOSPITAL (Address)                     

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL                      DATE OF BURIAL April 8, 1928

15 Filed 1928 C. HAMMOND JONES, Registrar

UNDERTAKER Thomas G. Nelson ADDRESS 303 Frostman St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32638

## CERTIFICATE OF DEATH.

E 32638

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital 8-13* ST., *8-13* WARD)2-FULL NAME *Edward G. Grogan, Jr.*(a) RESIDENCE NO. *1250 N. Bay*

(Usual place of abode)

Length of residence in city or town where death occurred *2 1/2* yrs. *2* mos. *27* ds.

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov. 12, 1925*

7 AGE

Years

Months

Days

*2**4**27*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Maryland*10 NAME OF FATHER *Ed. Grogan, Sr.*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Lithuania*12 MAIDEN NAME OF MOTHER *Vincenta Grogan*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Lithuania*

14

Informant

(Address)

*Ed. Grogan, Jr. 1250 N. Bay St.*

15

PR 9 - 1928

C. H. JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 8, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 8, 1928* to *April 8, 1928*that I last saw him alive on *April 8, 1928*and that death occurred, on the date stated above, at *12 45 p. m.*

The CAUSE OF DEATH\* was as follows:

*Large atheroma*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

*At home*

Did an operation precede death?

*Yes* Date of *4-8-28*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Bacteriological*

(Signed)

*J. R. Levin* M. D.4-7, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Rosary, April 7, 1928*

DEERTAKER

ADDRESS

*John M. Miller 4118 Chester*

E 32639

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001 E 32639

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 N Payson ST. 20th WARD 2nd)

### 2-FULL NAME

Marie Lanterboch

### (a) RESIDENCE NO.

114 N Payson

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? 37 yrs. 6 mos. 8 ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (write the name of HUSBAND or WIFE of deceased) Alfred E. Lanterboch

6 DATE OF BIRTH (month, day, and year) Sept. 18th. 1890

7 AGE Years 37 Months 6 Days 8 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) Baltimore, Md

10 NAME OF FATHER John Nelson

11 BIRTHPLACE OF FATHER (city or town, State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Mary E. Forrest

13 BIRTHPLACE OF MOTHER (city or town, State or country) Baltimore, Md

14 Informant (Name and Address) Alfred E. Lanterboch  
114 N. Payson St.

15 Date of death APR 9 - 1928

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th. 1928

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1928, to April 5, 1928, that I last saw him alive on April 3, 1928, and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Hypertension (duration) yrs. 10 mos. 10 ds.

18 Where was disease contracted if not at place of death? Park Heights & Pigeon

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical  
(Signed) Edw. G. Ford M. D.  
, 19 (Address) 5912 Park Heights

\*State the Disease Causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

Not interment April 9th. 1928  
20 UNDERTAKER W. H. Huppert ADDRESS 155 N. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32640

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. W. Balto Gen Hosp 16-68 Ward)

2-FULL NAME

Mary E. Barger

(a) RESIDENCE NO.

2835 W. Lammle Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color of Race White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1916

7 AGE Years 11 Months 11 Days 7 IF LESS than 1 day...hrs. or...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... School  
(b) General nature of industry, business, or establishment in which employed (or employer)...  
(c) Name of employer...

9 BIRTHPLACE (city or town) Balto and Md (State or country)

10 NAME OF FATHER

Mom's Barger

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MARRIED NAME OF MOTHER Martha E. Barger

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mom's Barger (Address) 2835 W Lammle

15 Filed 1928

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) And that said deceased came to death (on the day stated above.)

The CAUSE OF DEATH\* was as follows:

Lacerated Spleen.

CONTRIBUTORY (Secondary)

Auto Truck

(Signed) J. B. Lusk M. D. (Coroner)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence...

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Belton Park April 10 1928

UNDERTAKER W. B. Lusk ADDRESS 1850 W. Balto

very important. See instructions on back of certificate.

E 32641

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32641

### 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. BALTIMORE CITY HOSPITALS ST. 76-37 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Alexander Miotloski*

(a) RESIDENCE NO. *Rider Ave., Edgewater*  
(Usual place of abode)  
Length of residence in city or town where death occurred *22* yrs. *1* mos.

How long in U. S., if of foreign birth? *20* yrs. *1* mos. *1* ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of or WIFE of *Beatrice*

6 DATE OF BIRTH (month, day, and year) *Oct 16 1891*  
7 AGE *36* Years *5* Months *21* Days  
If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Solvent*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Poland*

10 NAME OF FATHER *Mathias Miotloski*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*

12 MAIDEN NAME OF MOTHER *Mary*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Poland*

14 Informant (Address) *Records*

15 Filed *19* *14* *HARRISON JONES, JR.* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/7/1928*

17 I HEREBY CERTIFY, That I attended deceased from *Apr. 3*, 1928, to *Apr. 7*, 1928 that I last saw him alive on *Apr. 7*, 1928 and that death occurred, on the date stated above, at *2:00 P. M.*  
The CAUSE OF DEATH\* was as follows:  
*Solvent pneumonia*

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? *3* Date of *no*  
Was there an autopsy? *no*

What test confirmed diagnosis? *General & Solvent*  
(Signed) *G. Holmes* M. D.  
19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER *Wendell Dippel*  
DATE OF BURIAL *April 19*  
ADDRESS *37 1st St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32642

E 32642

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 3-4 Ward)2-FULL NAME Amelia Sudelo(a) RESIDENCE NO. 128 S. Eden St

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

female

white

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofAdam Sudelo

6 DATE OF BIRTH (month, day, and year)

April 3/1887

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

41

0

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workAt home(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant  
(Address)Husband

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give his NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8/2817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.) and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Sinusitis- Purulent Meningitis  
Fracture of left Femur. Struck by  
Automobile at Central Ave & Lombard  
Apr 3/28CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

4/9/28 (Address)

508 E. North Ave\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificate.

APR 9 - 1928

G. H. H. 339

14

J. W. G. 1730 Eastern

1928

32643

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161-001 E 32643

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *16 Middle*)ST. *7* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — *Albert Kelly*(a) RESIDENCE. NO. *16 Middle*

(Usual place of abode)

ST. *7* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *April 7-28*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*1 hr.*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*

## 10 NAME OF FATHER

*John Kelly*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Baltimore*

## 12 MAIDEN NAME OF MOTHER

*Margaret M. Kelly*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore*

## 14

Informant  
(Address)*Mrs. Kelly  
16 Middle St.*

## 15

Filed

*1928**JOHN JONES, M. D.  
Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 7 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from  
*April 7 1928* to *April 7 1928*  
that I last saw him alive on *April 7 1928*  
and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH\* was as follows:

*Premature Birth*CONTRIBUTORY  
(Secondary)(duration) yrs. *6* mos. ds.*Faulty development*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*4/8, 1928* (Address) *1279 William St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Cathedral Ave.**April 9, 1928*

## 20 UNDERTAKER

## ADDRESS

*Margaret J. Flynn**1422 Light St.*

TION is very important. See instructions on back of card.

32644

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

74-001 E 32644

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 231 S. Greene

## 2-FULL NAME

Christian Fuchs

(a) RESIDENCE NO. 1346 Washington Boul. St.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Amelia Fuchs

## 6 DATE OF BIRTH (month, day, and year)

Dec. 10- 1863

## 7 AGE

Years

64

Months

3

Days

27

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Balto. Tube Co.

## 9 BIRTHPLACE (city or town)

(State or country)

Germany

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant

Mrs. Amelia Fuchs

(Address)

1346 Washington Boul.

## 15 Filed

1928 C. H. F. Jones

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 7

1928

## 17

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) Eugene J. Zeller, M. D.  
(Coroner)

4/8. 1928. (Address) 2739 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park

Apr 10 1928

## 20 UNDERTAKER

ADDRESS

Mrs. John W. Neufel &amp; Son 801 W. Fayette

Very Important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32645

## CERTIFICATE OF DEATH

91-002 E 32645

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 912 St Paul St 11-15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie R. Jackson

(a) RESIDENCE NO. 912 St Paul St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

August 1839

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

88

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Fredericksburg Va

(State or country)

10 NAME OF FATHER

William Jackson

11 BIRTHPLACE OF FATHER (City or town)

Fredericksburg Va

(State or country)

12 MAIDEN NAME OF MOTHER

Mary E. Riley

13 BIRTHPLACE OF MOTHER (city or town)

Winchester Va

(State or country)

14

Informant (Address)

Mrs. Gordon Steiner

15

Filed

G. HAMMOND JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 7 1928

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1928, to April 7, 1928, that I last saw her alive on April 7, 1928, and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Generalized Arteriosclerosis and Sclerosis (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. H. B. May, M. D. Apr 9, 1928 (Address) Medical Arts Building

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Fredericksburg, Va

4-10 1928

20 UNDERTAKER

ADDRESS

H. W. Jenkins &amp; Sons, Co.

Orchard Me. Center

very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32646

E 32646

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 808 Cathedral St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Harriet Hinkley

## (a) RESIDENCE NO.

808 Cathedral

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 10 mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female white single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

June 5 1862

## 7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

65 10 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Md

## 10 NAME OF FATHER

Edward Otis Hinkley

## 11 BIRTHPLACE OF FATHER (City or town)

Baltimore

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Anne M. Keenle

## 13 BIRTHPLACE OF MOTHER (city or town)

Philadelphia

(State or country)

Pa

## 14

Informant (Address)

John Hinkley (brother)  
215 N. Charles St

## 15

Date

1928 C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 1927, to April 8 1928

that I last saw him alive on April 8 1928

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Lung

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

Carcinoma

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampton Jones, M. D.

## 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Green Mount Cem

April 11 1928

## 20 UNDERTAKER

Henry H. Jenkins Sons Co

ADDRESS

McCulloch  
Orchard St.

E 32647

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32647

## CERTIFICATE OF DEATH.

161-001

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Etting

ST. 14-59 WARD

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Baby boy Newman

### (a) RESIDENCE NO.

2102 Etting

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

male

#### 4 COLOR OR RACE

black

#### 5 Single, Married, Widowed, or Divorced, (write the word)

#### 5a If married, widowed, or divorced (HUSBAND of (or) WIFE of)

✓

#### 6 DATE OF BIRTH (month, day, and year)

4-2-28

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

5

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

✓

(b) General nature of industry, business, or establishment in which employed (or employer)

✓

(c) Name of employer

✓

#### 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

#### 10 NAME OF FATHER

Shirley Diggs

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

?

#### 12 MAIDEN NAME OF MOTHER

Lillian Newman

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

M. Daniels Md.

#### 14

Informant (Address)

mother

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

4-5-1928

#### 17

I HEREBY CERTIFY, That I attended deceased from

4-1-1928, to 4-5-1928,

that I last saw him alive on 4-4-1928,

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. ds.

#### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. Alexander Hovey M. D.  
19 (Address) 1576 Madison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND

#### 20 UNDERTAKER

1000 E. ...

9 1928

G. HARRISON JONES, M. D. Registrar

APR 7 - 1928

E 32648

## HEALTH DEPARTMENT—CITY OF BALTIMORE

✓  
L032648

## CERTIFICATE OF DEATH. 161-001

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Harlem Ave

St. 16-22 Ward)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.. Baby Boy Johnson

(a) Residence No. 1412

Harlem Ave

St. .... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Black

5-Single,  
Married,  
Widowed,  
or Divorced.  
(Write the word.)5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

April 8, 28

7-AGE,

If LESS than 1 day,

yrs. .... mos. .... ds.

9-hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work.....(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).  
(State or Country),

Baltimore Md

10-NAME OF  
FATHER

James Evans

11-BIRTHPLACE  
OF FATHER (city or town)  
(State or Country),

Alexandria Va

12-MAIDEN NAME  
OF MOTHER,

Elizabeth Johnson

13-BIRTHPLACE  
OF MOTHER (city or town).  
(State or Country),

Va

14-

(Informant).....

(Address).....

15-

Filed

1921

C. HAMPSON JONES, M. D.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

4/4/28

17- I HEREBY CERTIFY, That I attended deceased from

April 4, 1928 to April 4, 1928

that I last saw him alive on April 4, 1928

and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH\* was as follows:

Prematurity  
Congenital Abortion

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary).....

(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted  
If not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis Phys exam

(Signed) ... M. D.

19 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR DATE OF BURIAL,

REMOVAL UNIVERSITY OF MARYLAND

20-UNDERTAKER,

Gannett Health.

ADDRESS

P. O. Box 1-1000

2334

E 32649

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32649

## CERTIFICATE OF DEATH.

161-001

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Jackson ST. 24-34 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bay Robertson

(a) RESIDENCE NO. 1810 Jackson

(Usual place of abode)

ST. 24-34 WARD

Length of residence in city or town where death occurred

1 hour 45 min.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year) April 8, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, 1 hrs. or 45 min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) 1810 Jackson ST  
(State or country) Baltimore, Md

10 NAME OF FATHER Robert Robertson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Josephine Trigg

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Newport News, Va

14

Informant  
(Address)

mother

15

Filed

19

C. HAMPSON JONES, M.  
2225 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 8, 1928, to April 8, 1928, that I last saw him alive on April 8, 1928, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Wiley, M. D.

, 19 (Address) 1516 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

HOPKINS HOSPITAL  
Commis. of Health

19

ADDRESS

APR 9 - 1928



32650

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32650

## CERTIFICATE OF DEATH.

161-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *160*)ST. *6-9* WARD)

## 2-FULL NAME

*Walter Williams*

## (a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*Black*5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*April 1, 1928*

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*Two*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

## 10 NAME OF FATHER

*Henry Williams*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

## 12 MAIDEN NAME OF MOTHER

*Alberta Edwards*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

## 14

Informant  
(Address)*Edith Conham*

## 15

*1928**C. HANSON JONES**Regist.*

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*April 3, 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*4-1, 1928, to 4-3, 1928,*that I last saw him alive on *4-3, 1928*and that death occurred, on the date stated above, at *10.00 A.m.*

The CAUSE OF DEATH\* was as follows:

*Prunaturity*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

## What test confirmed diagnosis?

(Signed)

*Edith Conham*

M. D.

(Address)

*Johns Hopkins Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

*Comptroller Health*

ADDRESS

*APR 9 - 1928*

E 32651

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32651

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *305 S. Robison*)ST. *1-2*

WARD)

2. FULL NAME *Richard K. Garner*(a) RESIDENCE NO. *305 S. Robison*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
or WIFE of6 DATE OF BIRTH (month, day, and year) *Mar 27 1927*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md*  
(State or country)10 NAME OF FATHER *Thomas M. Garner*11 BIRTHPLACE OF FATHER (city or town) *Va*  
(State or country)12 MAIDEN NAME OF MOTHER *Elsie Krupp*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md*  
(State or country)

14

Informant *Thomas M. Garner*  
(Address) *305 S. Robison*

15

Filed *1928*, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 8 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Mar 30*, 192*7*, to *Apr 8*, 192*8*,  
that I last saw him alive on *Apr 8*, 192*8*,  
and that death occurred, on the date stated above, at *9:10 P* m.  
The CAUSE OF DEATH\* was as follows:*Broncho pneumonia*(duration) yrs. mos. *9* ds.CONTRIBUTORY *measles and diphtheria*  
(Secondary)18 Where was disease contracted  
if not at place of death? *Yes*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *lung involvement*  
(Signed) *Dr. Mohr*, M. D.4 10, 192*7* (Address) *5015 Illinois*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Oak Lawn Cemetery*  
*Manah Canoles 1004 Arignith st*

E 32652

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32652

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *305 S. Robinson*St. *1-2*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Harry Garner*(a) RESIDENCE. No. *305 S. Robinson*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Mar 27<sup>th</sup> 1927*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**11 10*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Ans*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*Thomas M. Garner*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Li*

12 MAIDEN NAME OF MOTHER

*Eric Krupp*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore*

14

Informant (Address)

*Thomas M. Garner 305 S. Robinson St*

15

*1928*

19

*NOT*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Apr 7 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 31 1928 to Apr 7 1928*that I last saw him alive on *Apr 7 1928*and that death occurred, on the date stated above, at *4:35 P.M.*

The CAUSE OF DEATH\* was as follows:

*Bronchitis pneumonia*(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

*Measles 15 days before Pneumonia*18 Where was disease contracted *at home* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Leg. Malum* (Signed) *W. M. D.**4/7/28* (Address) *301 S. Ellwood*

\*State the Disease, Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cemetery**April 10 1928*

20 UNDERTAKER

ADDRESS

*Shannah Canoles 1004 Aisquith St*

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32653

## CERTIFICATE OF DEATH.

90 E 32653

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs.

St. Ward

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

15 Filled

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from March 25, 1928, to April 6, 1928, that I last saw him alive on April 5, 1928, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Organic Diseases of Heart

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS



E 32654 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3514 Virginia Ave. ST. 27-56 WARD 1

2-FULL NAME James E. Lane, Jr.

(a) RESIDENCE No. 3514 Virginia Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND or WIFE of Mary R. Lane

6 DATE OF BIRTH (month, day, and year) Nov. 7-1865

7 AGE Years 62 Months 5 Days 6 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railway &amp; Co

9 BIRTHPLACE (city or town) Green Anne Co Md (State or country)

10 NAME OF FATHER James H. Lane

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Emily Sorden

13 BIRTHPLACE OF MOTHER (city or town) Del (State or country)

14 Informant Mrs. Mary R. Lane (Address) 3514 Virginia Ave

15 Filed 1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1928, to April 8, 1928, that I last saw him alive on April 7, 1928, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH\* was as follows:

Influenza - pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert C. Knapp, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Woodlawn Cem

DATE OF BURIAL

4/10/28

20 UNDERTAKER J. J. Jones &amp; Co No Ave



32656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Street WARD 9-47)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

C. HAMPTON JONES, M. B.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

4/5/1928, to 4/9/1928,

that I last saw him alive on 4/9/1928,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Stroke pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) J. C. Feldman, M. D.

, 19 (Address) W. B. g H

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Loudon Park

Apr 10 1928

UNDERTAKER

ADDRESS

Wm J. Tucker

21 Pa

E 32657

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 32657  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 S. Clinton

2-FULL NAME ANNABELLE M. TUERS

(a) RESIDENCE NO. 1105 S. Clinton

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds.

ST. WARD

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31, 1926

7 AGE

Years

1

Months

8

Days

8

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Lawrence Tuers

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Viola Averser

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

PARENTS

14 Informant Mr. Lawrence Tuers (Father)

(Address)

1105 S. Clinton St.

15

1928

C. HANCOCK JONES, M. D.

Registrar

76-1

How long in U. S., if of foreign birth? yrs. mos. ds.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 8, 1928, that I last saw him alive on April 8, 1928, and that death occurred, on the date stated above, at 11.05 p. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 10 ds. CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 3 ds. 18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation (Signed) H. B. Titlow, M. D. 1928 (Address) 315 S. Highland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Carmel Cemetery

20 UNDERTAKER

Henry Sander & Sons Inc

DATE OF BURIAL

April 10, 1928

BROADWAY & BALTIMORE ST



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32658

E 32658

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Md Emma Doyle

REGISTERED NO.

City of BALTIMORE: (No. *Madison & Leiden St.* Ward)

2-FULL NAME

Joseph J. Armacost

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Hampstead St. Md

(Usual place of abode)

Length of residence in city or town where death occurred

14

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Nattie Armacost

6 DATE OF BIRTH (month, day, and year)

10-22-1894

7 AGE

53

5

17

IF LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer)

Lumber

(c) Name of employer

Bry

9 BIRTHPLACE (city or town)

(State or country)

Barto Co. Md

10 NAME OF FATHER

Daniel M. Armacost

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Barto Co. Md

12 MAIDEN NAME OF MOTHER

Maudie Winters

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Barto Co. Md

14

Informant (Address)

Hypatia Reed

15 F

G. HANSON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-9-28

17

I HEREBY CERTIFY, That I attended deceased from

3-23-28, 19, to 4-9-28, 19

that I last saw him alive on 4-9-28, 19

and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH\* was as follows:

Cause of Death (Epithelioma)

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 7 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

Yes Date of 3-3-28

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease, Cause of Death, and (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Salem Cem. Balto Co

4-12-28

UNDERTAKER

ADDRESS

Edw. Tipton Hampstead Md

very important. See instructions on back of certificates.

(Morawe)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

32659

32659

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4100 Rosedale Ave. 27-41 St., 27-41 Ward)

Registered No. ....

## 2-FULL NAME. William H. Morawe

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 4100 Rosedale Ave.

(Usual place of abode)

St. .... Ward. ....

Length of residence in city or town where death occurred

yrs. 1 mos. 19 ds.

How long in U. S., if of foreign birth?

yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-Single,

Married,

Widowed,

or Divorced,

(Write the word.)

Single

5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of6-DATE OF BIRTH (month, day and year) Feb 20<sup>th</sup> 1928

7-AGE.

yrs. 1 mos. 19 ds.

If LESS than 1 day,

hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work.

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town)  
(State or Country).

Baltimore Md

10-NAME OF  
FATHER

Herman F. Morawe

11-BIRTHPLACE  
OF FATHER (city or town)  
(State or Country).

Germany

12-MAIDEN NAME  
OF MOTHER

Antonia Greiss

13-BIRTHPLACE  
OF MOTHER (city or town)  
(State or Country).

Baltimore Md

11-

(Informant)

Herman F. Morawe

(Address)

4100 Rosedale Ave.

15-

Filed 9-1928

C. HAMMON JONES, M.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

April 9, 1928

17-

I HEREBY CERTIFY, That I attended deceased from

April 6, 1928 to April 9, 1928

that I last saw him alive on April 8, 1928

and that death occurred, on the date stated above, at 4:10 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia - Bronchitis

(Duration) yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. .... mos. .... ds.

18-Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4.9.1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes  
state (1) Means and Nature of Injury, and (2) whether Accidental  
Suicidal, or Homicidal. (See reverse side for additional space)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL

DATE OF BURIAL

Trinity Cem

April 10, 1928

20-UNDERTAKER

ADDRESS 1037

Eschman &amp; Son

Baltimore

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32660

32660

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3712 Winterbourne Road* ST. *15-66* WARD *89*)

### 2-FULL NAME

(a) RESIDENCE NO. *3712 Winterbourne Road* ST. *15-66* WARD *89*  
(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *W.* 5 ~~Single, Married, Widowed, or Divorced~~, (write the word) *Widow.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Francis M. Young*

6 DATE OF BIRTH (month, day, and year) *Apr 12 1858*

7 AGE Years *69* Months *11* Days *26* If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer) *Home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*

10 NAME OF FATHER *Jacob Patterson*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md*

12 MAIDEN NAME OF MOTHER *Anna M. Mopch*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14 Informant *Miss Minnie Young* (Address) *3712 Winterbourne Road*

15 *9-1928* *HANCOCK JONES, M.D.*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 8 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Dec 15*, 19*27*, to *April 8*, 19*28*.

that I last saw him alive on *April 24*, 19*28*.

and that death occurred, on the date stated above, at *1245 P.* m.

The CAUSE OF DEATH\* was as follows:

*Coronary artery thrombosis (Angina pectoris)*

(duration) yrs. mos. ds. *1*

CONTRIBUTORY (Secondary) *Arteriosclerosis* (duration) yrs. mos. ds. *4*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Laurel P. Hamburger* M. D. *April 9, 1928* (Address) *1207 Eutaw Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *London Park Cemetery* DATE OF BURIAL *Apr 10 1928*

20 UNDERTAKER *William J. Jones* ADDRESS *1720 N. Lafayette St.*

232661

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44E 32661

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

JOHNS HOPKINS HOSPITAL

ST. 6-10 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Gottlieb Baum

### (a) RESIDENCE NO.

2 N. Cal-

(Usual place of abode)

Length of residence in city or town where death occurred

81 yrs. 4 mos. 23 ds.

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

ys. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### SEX

male

#### 4 COLOR OR RACE

white

#### 5 Single, Married, Widowed, or Divorced, (write the word)

widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

Nov. 14-1844

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

81

4

23

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

out

(c) Name of employer

### 9 BIRTHPLACE (city or town) (State or country)

md

### 10 NAME OF FATHER

John Baum

### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

### 12 MAIDEN NAME OF MOTHER

Calvin Sykes

### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

### 14

Informant

(Address)

JOHNS HOPKINS HOSPITAL

### 15

File

1928

G. HAMPTON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

April 7 1928

#### 17

HEREBY CERTIFY, That I attended deceased from

Mar 26, 1928, to April 7, 1928.

that I last saw him alive on April 7, 1928,

and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Stomach.

(duration) yrs. 3 mos. 3 ds.

#### CONTRIBUTORY (Secondary)

Pneumonia.

(duration) yrs. mos. 3 ds.

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Operation. Autopsy

(Signed)

J. S. Hagg, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Carmel Cem. Apr. 10 1928

#### 20 UNDERTAKER

ADDRESS

Mr. G. Blacke 927 N. Broadway



E 32662

# HEALTH DEPARTMENT—CITY OF BALTIMORE

47E 32662

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Jackson

ST. 24-34 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond J. Earley.

(a) RESIDENCE No. 1721 Jackson

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 40 yrs. 5 mos.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel Earley.

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1888

7 AGE Years 40, Months 5, Days 3 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B. & O. R. R. Conductor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Jerry Earley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Webb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Isabel Earley. (Address) 1721 Jackson St.

15 1928 C. HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 19 28

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 19 27, to April 8, 19 28, that I last saw him alive on April 7, 19 28, and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH\* was as follows:

Purpura of Stomach

CONTRIBUTORY (Secondary) (duration) yrs. 4 mos. ds. E. Earley

(duration) yrs. mos. ds. 7

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of Jan 18 28

Was there an autopsy?

What test confirmed diagnosis? (Signed) R. B. Campbell, M. D. 4/8, 1928 (Address) 1640 ...

\*State the Disease Causing Death, as from Violent Causes, state (1) Means and Nature of Injury (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL DATE OF BURIAL

20 UNDERTAKER A. Howard Evans 35 E. Fort Ave

22823  
232663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126 E 32663

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3-5 ST. 3-5 WARD)

2-FULL NAME Joseph Galecin

(a) RESIDENCE NO. 115- Lloyd

ST. City WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. 16 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia Galecin

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE Years 42 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labrer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy (State or country)

10 NAME OF FATHER Mike Galecin

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Mary Galecin

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Records (Address)

15 1928 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1928

17 I HEREBY CERTIFY, That I attended deceased from April 5-1928 to April 9 1928 that I last saw him alive on April 9 1928 and that death occurred, on the date stated above, at 125-04 in.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Polyneuritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted abroad if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Sydney M. Jones M. D.

49 1928 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer DATE OF BURIAL April 10, 1928

20 UNDERTAKER Frank V. Piperton ADDRESS 2518 E. Baltimore

32664

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32664

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE:

## 2. FULL NAME

(a) RESIDENCE NO. (Usual place of abode)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Elizabeth Clark

6 DATE OF BIRTH (month, day, and year)

Apr 7 1859

7 AGE

68

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retiree

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

Kent Co. Maryland

10 NAME OF FATHER

Samuel Clark

11 BIRTHPLACE OF FATHER (city or town, State or country)

Kent Co. Maryland

12 MAIDEN NAME OF MOTHER

Julia Lussay

13 BIRTHPLACE OF MOTHER (city or town, State or country)

Kent Co. Md Maryland

14

Informant (Address)

George S. Clark 3416 Edmondson Ave.

15

1928

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 8 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr 4 1928 to Apr 8 1928

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Influenza.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. J. French, M. D.

8. 1928 (Address) 1705 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Brompton Md.

DATE OF BURIAL

Apr 9 1928

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. Walters

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32665

## CERTIFICATE OF DEATH.

181-001  
E 32665

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Ignace Church St. Record Ward)

## 2-FULL NAME

(a) RESIDENCE NO. Calvert & Madison St. Record Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 18517 AGE Years 76 Months 8 Days 22 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

10 NAME OF FATHER Unobtainable

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Records Loyola College  
Calvert & Madison St.

15

1828

C. HANSON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Asphyxiation due  
to gas from accidentally started burning  
gas stove (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. H. Jones M. D.

(Coroner)

, 19 28 (Address) 1639 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death:

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Woodstock, Md. 4/10 1928

20 UNDERTAKER

ADDRESS

Henry W. Messersmith 800 N. Calvert



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32666

## CERTIFICATE OF DEATH.

37-E 32666

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *617 Mc Kervin Ave*)

### 2-FULL NAME

(a) RESIDENCE NO. *617 Mc Kervin Ave*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*

4 COLOR OR RACE *W*

5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 1, 1905*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*22*
*10*
*7*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balt Md*

10 NAME OF FATHER *William Letsch*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balt Md*

12 MAIDEN NAME OF MOTHER *Marion Schefflin*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balt Md*

14

Informant (Address) *Augusta Denslering 617 Mc Kervin Ave*

15

Filed *1928*

19

HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 8 1928*

17

I HEREBY CERTIFY, That I attended deceased from *January 1, 1928*, to *April 8, 1928*, that I last saw her alive on *April 7, 1928*, and that death occurred, on the date stated above, at *2:30 A* m. The CAUSE OF DEATH\* was as follows:

*Acute Miliary Tuberculosis*

(duration) yrs. *3* mos. *8* ds.

CONTRIBUTORY (Secondary) *Heart Failure*

(duration) yrs. *3* mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Physician* (Signed) *Henry J. Haberk*, M. D.

4/8, 1928 (Address) *2000 Monument St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Not Cremel*
*Apr 11 1928*

20 UNDERTAKER

ADDRESS

*Wm Cook*
*500 E North Ave*

32667

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3005 West North Ave. ST. 15-67 WARD 90)

2-FULL NAME Robert W. Adams

(a) RESIDENCE No. 3005 West North Ave ST., WARD  
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Adams

6 DATE OF BIRTH (month, day, and year) Oct 2-1854

7 AGE Years 73 Months 6 Days 7 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt  
(b) General nature of industry, business, or establishment in which employed (or employer) Retired  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Albert Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Caroline See

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ethel V. Cochran  
(Address) 3005 West North Ave

15 Filed 1928 C. HANCOCK JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9<sup>th</sup> 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1926 to April 9, 1928, that I last saw him alive on April 9, 1928, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH\* was as follows:

Chronic valvular cardiac disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? (Signed) Frank H. Rubin M. D.

49, 1928 (Address) 3005 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Cemetery

4/11-1928

UNDERTAKER

ADDRESS

William Cook

502 E North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32668

## CERTIFICATE OF DEATH.

31 E 32668

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1804 E. Eager

St. 7-13 Ward

2-FULL NAME David H. Jones

(a) RESIDENCE NO. 1804 E. Eager

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

col

5 Single, Married, Widowed,  
or Divorced, (write the word)  
married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Carrie E. Jones

6 DATE OF BIRTH (month, day, and year)

Oct 5/1866

7 AGE

Years

61

Months

6

Days

2

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(Halethorpe Sta.)

(c) Name of employer B &amp; O R.R.

9 BIRTHPLACE (city or town)

Northumberland Co

(State or country)

Va.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant Carrie E. Jones

(Address) 1804 W Eager St.

15

Filed

1928

C. HAMMON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 7/28

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Hemorrhage-Probably Pulmonary

(Probably Tuberculosis)

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)(Signed) J. J. Jones, M. D.  
(Coroner)

4/9/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Asbury Cemetery

4-10 1928

20 UNDERTAKER

ADDRESS

Mrs L. H. Bailey 1421 Jefferson St

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

APR 9 - 1928

E 32669

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HON. ST. 22-30)

## 2-FULL NAME

Edna McCreary or L. Green

## (a) RESIDENCE NO.

116 Wellesley Alley ST.

(Usual place of abode)

## WARD

Length of residence in city or town where death occurred

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Common law wife

## 5a If married, widowed or divorced, HUSBAND of (or) WIFE of

Pleasant Broadbent

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

37

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Md

## 10 NAME OF FATHER

Ross McCreary

## PARENTS

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

West Indies

## 12 MAIDEN NAME OF MOTHER

Louisa Beth

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

## 14

Informant (Address)

Record

## 15

Filed

APR 10 1928

HAYDEN JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

4-8

1928

## 17

I HEREBY CERTIFY, That I attended deceased from 4-5, 1928, to 4-8, 1928,

that I last saw her alive on 4-8, 1928,

and that death occurred, on the date stated above, at 6:15 A. M.

The CAUSE OF DEATH\* was as follows:

Vincent's Angina  
Broncho-Pneumonia

(duration) yrs. mos. 8 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Holmes Bryant, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Calvary

## UNDERTAKER

John H. Toadum

## DATE OF BURIAL

4-11-28

## ADDRESS

1027 Sand Hill



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32670

## CERTIFICATE OF DEATH.

74-001  
E 32670

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Harvest Road ST., 7 WARD)

### 2-FULL NAME

Hesterlena Aspril

### (a) RESIDENCE NO.

7 Harvest Road

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 40 mos. 40 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 28 - 1833

7 AGE

Years 95 Months 1 Days 15 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Delaware

10 NAME OF FATHER

John Aspril

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Martha Munday

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Delaware

14

Informant (Address)

Mr. W. Albert Johnson  
7 Harvest Road

15

Filed

10 1928

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1928

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1928, to April 9, 1928, that I last saw her alive on April 8, 1928, and that death occurred, on the date stated above, at 3-40 a. m.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage  
Left Hemiplegia

CONTRIBUTORY (Secondary) Senile Arteriosclerosis (duration) 7 yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis of Left Arm  
(Signed) Mr. Gibson Porter, M. D.

4/9, 1928 (Address) 422 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Wheaton Delaware Mar 11, 28

UNDERTAKER

ADDRESS

W. S. Marshall 3539 Fall Rd

# HEALTH DEPARTMENT--CITY OF BALTIMORE

E 32671

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *13 Bushman* ST. *Hamilton* WARD)

### 2-FULL NAME

(a) RESIDENCE NO. *13 Bushman* ST. *Hamilton* WARD  
(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. *0* mos. *0* ds.

REGISTERED NO. *101-001*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

1 SEX *Female*  
2 COLOR OR RACE *White*  
3 Single, Married, Widowed, or Divorced? (write the word) *Married*  
4 If married, widowed, or divorced HUSBAND or (or) WIFE of *Les. H. Curran*  
5 DATE OF BIRTH (month, day, and year) *April 5, 1857*  
6 AGE Years *71* Months *0* Days *3*  
7 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 9 BIRTHPLACE (city or town)

*Harford County, Maryland*

### 10 NAME OF FATHER

*Henry Fowler*

### 11 BIRTHPLACE OF FATHER (city or town)

*Harford County, Maryland*

### 12 MAIDEN NAME OF MOTHER

*Robert Rockhold*

### 13 BIRTHPLACE OF MOTHER (city or town)

*Harford County, Maryland*

### 14

Informant (Address) *13 Bushman St. Hamilton Ward*

### 15

Died *APR 10 1928*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 8, 1928*

17 I HEREBY CERTIFY, That I attended deceased from *March 15, 1928*, to *April 8, 1928*, that I last saw him alive on *April 7, 1928*, and that death occurred, on the date stated above, at *2 a m.*

The CAUSE OF DEATH\* was as follows:

*Coro-Vascular Dis. - Atherosclerosis*

### CONTRIBUTORY (Secondary)

*Pneumo. Pneumonia* (duration) *1* yrs. *0* mos. *0* ds.

18 Where was disease contracted If not at place of death? *✓*

Did an operation precede death? *no* Date of *✓*

Was there an autopsy? *no*

What test confirmed diagnosis? *✓*

(Signed) *Frank B. Jones* M. D.

(Address) *125 S. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

*Oak Lawn Cemetery*

### 20 UNDERTAKER

*B. W. Waples, 150 N. Calhoun St.*

### DATE OF BURIAL

*April 10, 1928*

### ADDRESS

E 32672

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32672

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2730 Harford* ST., *46* WARD)2. FULL NAME *Charles B. Heer*(a) RESIDENCE NO. *2730 Harford* ST., *46* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *12* yrs. *7* mos. *25* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male*4 COLOR OR RACE *White*5 Single Married, Widowed, or Divorced, (write the word) *Single*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) *Jan 16 1926*

AGE

Years *12*Months *7*Days *25*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School Pupil*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto. Md.*10 NAME OF FATHER *Mr. J. Heer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto. Md.*12 MAIDEN NAME OF MOTHER *May C. Lentz*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto. Md.*

14

Informant *Mr. J. Heer*(Address) *2730 Harford*

15

Filed *1928*

19

H&amp;M

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 8 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 23 1928, to April 8 1928,*that I last saw him alive on *April 8 1928,*and that death occurred, on the date stated above, at *12:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Purulent Pericarditis  
Empyema*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Staphylococci - 3 in Septicemia**7 days* (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Blood culture &*(Signed) *Amelia V. Zimmerman*, M. D.1928 (Address) *1805 W. North Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

PLACE OF BURIAL

UNDERTAKER

ADDRESS

*Frederick Park Cemetery Phila. 1928  
R. W. Hippert, 153 W. Balto. St.*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32673

## CERTIFICATE OF DEATH.

E 32673

1-PLACE OF DEATH

Sydenham Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 5-8 WARD)

2-FULL NAME

Arvo Michelson

(a) RESIDENCE No.

912 E. Baltimore

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ST.

WARD

(If non-resident give city or town and State)

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb - 8, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

2

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Gerson Michelson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Fannie Cohen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

Sydenham Hosp. Records

15

Filed

19

Klyc Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/9 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 25, 1928, to April 9, 1928,

that I last saw him alive on April 7, 1928,

and that death occurred, on the date stated above, at 6:35 P. M.

The CAUSE OF DEATH\* was as follows:

Measles

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) Dr. Sachman M. D.

4/9, 1928 (Address) Sydenham Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Home/Russ

DATE OF BURIAL

4/10 1928

20 UNDERTAKER

Jack Lewis 1439 560072

ADDRESS



# HEALTH DEPARTMENT—CITY OF BALTIMORE E 32674

32674

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hehem aged Hom 27-56* ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

*Mary Weinberg*

(a) RESIDENCE NO.

(Usual place of abode)

*Belcherdes & Greenleafing ave*

WARD

Length of residence in city or town where death occurred

*27* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

*27* yrs.

mos.

ds.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced, (write the word)

*widow*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Moses Weinberg*

6 DATE OF BIRTH (month, day, and year)

7 AGE

*80*

Years

Months

Days

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*old age*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Russia*

10 NAME OF FATHER

*Louis Meister*

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Anton*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Russia*

14

Informant (Address)

*David Weinberg 918 E Baer St*

15

Filed

*APR 10 1928*

*C. H. HARRIS, JONES, M.*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4/9 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Dec-15*, 19 *27*, to *April-9*, 19 *28*.

that I last saw him alive on *April-1*, 19 *28*, and that death occurred, on the date stated above, at *8:00 P* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Phthisis*

CONTRIBUTORY (Secondary) *acute nephritis* (duration) yrs. mos. ds.

(duration) yrs. mos. *5* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *renal analysis* (Signed) *Herman Sude* M. D.

, 19 (Address) *2104 East Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Hehem Harin Ben*

*4/10 1928*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 E Baer St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32675

E 32675

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Colonial Hospital

REGISTERED NO.

City of BALTIMORE: (No.

1122 N. Mount St. 14-20 Ward)

2-FULL NAME

Philip Daniels

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1510 Rutter

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. da.

How long in U. S. if of foreign birth?

yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie Daniels

6 DATE OF BIRTH (month, day, and year)

Sept 1st

1853

7 AGE

75

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter 90

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Maryland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Annie Daniels  
1510 Rutter

15 Filed

R 10 1928

G. H. HANCOCK, JR., M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-7 1928

17

I HEREBY CERTIFY, That I attended deceased from

2-4, 1928, to 4-7, 1928.

that I last saw him alive on 7th of April, 1928.

and that death occurred, on the date stated above, at 7:40 P. M.

The CAUSE OF DEATH\* was as follows:

Generalized Arteriosclerosis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 63 da.

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Julius Bralato, M. D.

19 (Address) Colonial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Pleasant Hill Cem 4-10-28

20 UNDERTAKER

ADDRESS

Samuel Henry Miller

E 32676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 32676

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4028 Wallad* ST. *20-71* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Anna Marie Busch*

(a) RESIDENCE NO.

*4028 Wallad*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

*70* yrs. *0* mos. *11* ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX

*Female*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

If married, widowed, or divorced HUSBAND of (or) WIFE of

*Wm Busch*

DATE OF BIRTH (month, day, and year)

*Mar 27<sup>th</sup> 1858*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*70*

*0*

*11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Self*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore MD*

10 NAME OF FATHER

*Carl Kern*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Margaret Batchelder*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Charlotte Busch 4028 Wallad ave*

15

Filed

PR 10 1928

*W. H. Jones, Jr.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Apr 9<sup>th</sup> 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 25*, 1928, to

*April 7*, 1928.

that I last saw her alive on

*April 7*, 1928.

and that death occurred, on the date stated above, at

*11:25 P.* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Gall Bladder  
Endocarditis, Atherosclerosis  
(C jaundice)*

CONTRIBUTORY (Secondary)

*Unknown*

18 Where was disease contracted if not at place of death?

*Yes*

Did an operation precede death?

*No*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Clinical*

(Signed)

*Robert E. Hickey, M. D.*

(Address)

*2607 Wilshire ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Louisa Park*

DATE OF BURIAL

*4/10/1928*

ADDRESS

UNDERTAKER

*Edmondson 2503*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32677

## CERTIFICATE OF DEATH.

E 32677

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Little Sisters of the Po 10-14* Ward)

## 2-FULL NAME

*Valentine Stempfer*

## (a) RESIDENCE NO.

*Preston + Valley*

St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

## 17

I HEREBY CERTIFY, That I attended deceased from

4/5, 1928, to 4/9, 1928,

that I last saw him alive on 4/8, 1928,

and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH\* was as follows:

*Atherosclerosis*

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

## 18 Where was disease contracted

If not at place of death

Did an operation precede death?.....Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Dr. Demetrius M. D.*49, 1928 (Address) *914 E. Pratt St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Holy Rosary April 11 1928*

ADDRESS

*W. Gazeuski 1930**Baltimore*

Filed 1928

C. H. JONES, Jr.

Registrar

very important. See instructions on reverse side.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32678

## CERTIFICATE OF DEATH.

125 E 32678

1. PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.

ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Mary Holmes

(a) RESIDENCE NO.

(Usual place of abode)

1516 Carter

ST.

WARD

City

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

Black

married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

Eliak Holmes

7 DATE OF BIRTH (month, day, and year)

February 1881

AGE

Years

Months

Days

If LESS than 1 day... hrs. or min.

7 7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None - go

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Lynchburg

10 NAME OF FATHER

Chas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ga.

12 MAIDEN NAME OF MOTHER

Josephine Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ga.

14

Informant (Address)

Records -

15

Filed

19

R. A. Ellis Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1928

17

I HEREBY CERTIFY, That I attended deceased from April 5 1928 to April 5 1928, that I last saw her alive on April 5 1928, and that death occurred, on the date stated above, at 4:55 P. m.

The CAUSE OF DEATH\* was as follows:

acute pancreatitis

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

intestinal obstruction?

Wanna

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

yes

Date of April 6, 1928

Was there an autopsy?

no

What test confirmed diagnosis?

seen at operation

(Signed) William M. Miller, M. D.

4/9 1928 (Address) The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Lester Manor Va

April 16, 1928

UNDERTAKER

ADDRESS

Mrs. R. A. Ellis

225 Ashland

E 32679 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 253 S. Hallas ST. 3-4 WARD)

## 2-FULL NAME Eleanor Rector

(a) RESIDENCE NO. 253 S. Hallas

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of John H. Rector

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

approx 55

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

house wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pocomoke City Md.

10 NAME OF FATHER Jesse Whittington

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER Alice Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

John Rector (husband) 253 S. Hallas St.

15

Filed

PR 10 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 3 1928 to April 6 1928

that I last saw him alive on April 6 1928

and that death occurred, on the date stated above, at 10:10 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration)

yrs.

mos

4 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Physical

(Signed)

April 28

(Address)

1424 Eastman St. M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

Mrs. R. G. Elliott

ADDRESS

1725 Ashland

E 32680

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 27-48 147E 32680  
 CITY OF BALTIMORE: (No. ST. WARD) REGISTERED NO.  
 2-FULL NAME Flanna Armushkin (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 (a) RESIDENCE NO. 6011 Presbiterian ST. WARD Gerard  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) married  
 If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Armushkin  
 DATE OF BIRTH (month, day, and year) 7-22-91  
 AGE Years Months Days If LESS than 1 day, hrs. or min.  
36 8 17

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

### BIRTHPLACE (city or town) (State or country)

Ind -

10 NAME OF FATHER James Edwards  
 11 BIRTHPLACE OF FATHER (city or town) Pa  
 (State or country)  
 12 MAIDEN NAME OF MOTHER Letha Saunders  
 13 BIRTHPLACE OF MOTHER (city or town) Pa  
 (State or country)

14 Informant JOHNS HOPKINS HOSPITAL  
 (Address)

15 APR 10 1928 JOHNS HOPKINS HOSPITAL  
 Registered

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1928  
 17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1928, to April 9, 1928, that I last saw her alive on April 9, 1928, and that death occurred, on the date stated above, at 7:00 a.m.  
 The CAUSE OF DEATH\* was as follows:  
Thrombo phlebitis  
(Post - delivery)

(duration) yrs. 1 mos. 17 ds.  
 CONTRIBUTORY bronchopneumonia  
 (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?  
 Did an operation precede death? no Date of  
 Was there an autopsy? yes  
 What test confirmed diagnosis? autopsy  
 (Signed) W. H. Williams, M. D.  
4-10-1928 (Address) JOHNS HOPKINS HOSPITAL

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
 MOVAL St. Calvary DATE OF BURIAL April 16, 28  
 UNDERTAKER Mrs. R. G. Elliott ADDRESS Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32681

## CERTIFICATE OF DEATH.

REGISTERED NO. E 32681

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *md Gen Hosp 11-24* St. *11-24* Ward)2-FULL NAME *Charles Brown*(a) RESIDENCE NO. *Bedwin md* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *res. Resident* (If not resident give city or town and State) U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male white* 4 Color or race *Widower* 5 Single, Married, Widowed, or Divorced, (write the word)5a If married, widowed, or divorced HUSBAND of (or) WIFE of *unknown*6 DATE OF BIRTH (month, day, and year) *1868*7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. *64*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Huckster*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *md*

(State or country)

10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) *md* (State or country)12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) *md* (State or country)14 Informant *Mrs John Whner* (Address) *400 Barclay*

APR 10 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/8 1928*17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Bone Fracture Skull*CONTRIBUTED *Kicked by horse* (duration) yrs. mos. ds. (Secondary)(Signed) *G. E. Smith* M. D.(Coroner) *md* (Address) *md*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL *buried in md* Date of Burial *April 11 1928*20 UNDERTAKER *J. Ben* ADDRESS *156 N. Luzerne ave.*

very important. See instructions on back.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32682

## CERTIFICATE OF DEATH.

129 E 32682  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 W. Saratoga Street 18-76 WARD)

## 2-FULL NAME

Rebecca Benett

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No.

1120 W. Saratoga Street

(Usual place of abode)

## WARD

Length of residence in city or town where death occurred

30 yrs.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced, (write the word)  
Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Jas. H. Benett

## 6 DATE OF BIRTH (month, day, and year)

March 2nd. 1874

## 7 AGE

Years

Months

Days

54

0

25

If LESS than  
1 day, hrs  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Benton  
Carroll Co., Md.

## 10 NAME OF FATHER

Augustus Wisher

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Carroll Co., Md.

## 12 MAIDEN NAME OF MOTHER

Martha Mutchenson

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Carroll Co. Md.

## 14

Informant  
(Address)

Jessie Benett

1120 Saratoga Street

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Aug. 1st, 1928, to April 7th, 1928.that I last saw her alive on Apr 1 7th. 1928  
and that death occurred, on the date stated above, at 10.48 m.

The CAUSE OF DEATH\* was as follows:

Ch. Interstitial Nephritis

(duration) yrs. 9 mos. 7 ds.

CONTRIBUTORY  
(Secondary)

Mitral Ins.

(duration) yrs. 4 mos. 20 ds.

18 Where was disease contracted  
if not at place of death?

At place of death

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.  
(Address) 1631 W. Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

Registrar

APR 10 1928

M Zion Cemetery  
Mrs. Hales R. WilliamsApril 11 1928  
Schroeder

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32683

## CERTIFICATE OF DEATH.

129 E 32683

1-PLACE OF DEATH

Sinai Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 3-5 WARD)

2-FULL NAME

Frank Greenberg

(a) RESIDENCE NO.

109 Alhermarck St.

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 25 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Wht

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Lena Greenberg

6 DATE OF BIRTH (month, day, and year)

March 11, 1898

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

39

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Frank Greenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Antonina

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Lena Greenberg 109 Alhermarck St.

15

APR 10 1928

H. J. K. M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-10-28

17

I HEREBY CERTIFY, That I attended deceased from

3-11-28, to 4-10-28.

that I last saw him alive on

4-10-28

and that death occurred, on the date stated above, at

7th

The CAUSE OF DEATH\* was as follows:

Pulmonary infarction  
Cardiac infarction

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Hypertension, chr.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

M. D. Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Hebrew Friedhof Cemetery

4/10 1928

20 UNDERTAKER

ADDRESS

J. L. Lewis 1439 E. 11th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE **32684****32684**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. **891 N. Lombard St. 76**)2-FULL NAME **Charles Semon**(a) RESIDENCE NO. **891 N. Lombard St.**

(Usual place of abode)

Length of residence in city or town where death occurred **50** yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX **M**4 COLOR OR RACE **W**5 Single, Married, Widowed, or Divorced, (write the word) **Widowed**6a If married, widowed, or divorced, HUSBAND of (or) WIFE of **Ely Semon**6 DATE OF BIRTH (month, day, and year) **June 1845**

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

**82****10**

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **Shoemaker**(b) General nature of industry, business, or establishment in which employed (or employer) **Self**

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) **Germany**10 NAME OF FATHER **don't know**11 BIRTHPLACE OF FATHER (city or town) (State or country) **Germany**12 MAIDEN NAME OF MOTHER **Lyndeen**13 BIRTHPLACE OF MOTHER (city or town) (State or country) **Germany**

14

Informant (Address) **Lizette Semon**

15

Filed

**PR 10 1928****C. H. Jones, Registrar**

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **Apr. 7. 1928**17 I HEREBY CERTIFY, That I attended deceased from **Mar 15, 1928** to **Apr 7, 1928**, that I last saw him alive on **Apr 7, 1928**, and that death occurred, on the date stated above, at **10 P. m.**

The CAUSE OF DEATH\* was as follows:

**Chronic Int. Nephritis**(duration) **1** yrs. **1** mos. **1** ds.CONTRIBUTORY (Secondary) **none**(duration) **1** yrs. **1** mos. **1** ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? **no** Date ofWas there an autopsy? **no**What test confirmed diagnosis? **Urinal Analysis Etc**(Signed) **Phas. Linton**, M. D.(Address) **888 N. Lombard St.**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1)—Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

**Indor Dubben****4/12/1928**

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32685

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital 9-17 Ward)2-FULL NAME Catherine Floyd Davies(a) RESIDENCE NO. Phila Road nr Poplar Road Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced  
HUSBAND of J. Oliver Davies, M.D.  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20-1873

7 AGE 54 Years 55 Months 3 Days 20 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed. (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.  
(State or country)

10 NAME OF FATHER William Floyd

11 BIRTHPLACE OF FATHER (city or town) Va  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)

14 Informant Husband  
(Address)

15 Filed 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
Arteriosclerosis (Autopsy at  
Chr. Nephritis St. Joseph)

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) John H. Miller M. D.

(Coroner)

4-10-28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death!

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Greenmount Cem Apr 12-28

20 UNDERTAKER

ADDRESS

John Miller 2108  
Arlee Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32686

## CERTIFICATE OF DEATH.

E 32686

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *6300 Brook Ave* ST. *27-42* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Selma-Q Muths*(a) RESIDENCE NO. *6300 Brook Ave*

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred *31* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *William R Muths*6 DATE OF BIRTH (month, day, and year) *12/9/1872*7 AGE Years *55* Months *43* Days *29* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Robert Kohn*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *William Muths* (Address) *6300 Brook Ave*15 Filed *APR 10 1928* C. HAYDON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 8 1928*17 I HEREBY CERTIFY, That I attended deceased from *Apr 8*, 19 *28*, to *Apr 8*, 19 *28*, that I last saw him alive on *Apr 8*and that death occurred, on the date stated above, at *9:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Acute Hemorrhage*CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *Acute Hemorrhage*

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *W. H. Taylor*, M. D. *Apr 28* (Address) *1520 E. 3rd St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Trinity Church*DATE OF BURIAL *Apr 11 1928*20 UNDERTAKER *John W. W. W.*ADDRESS *2008*

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

32687

## CERTIFICATE OF DEATH.

90

E 32687

REGISTERED NO.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST., \_\_\_\_\_ WARD)

2. FULL NAME *George W. French*(a) RESIDENCE NO. *1511 Orleans* ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *74* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX \_\_\_\_\_ 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

a If married, widowed, or divorced HUSBAND of \_\_\_\_\_ or WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *2/7/1854*AGE Years \_\_\_\_\_ Months *2* Days *28* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *mechanist*

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) *Maryland*10 NAME OF FATHER *Joseph James French*11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) *France*12 MAIDEN NAME OF MOTHER *Emily Wilson*13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) *Maryland*14 Informant \_\_\_\_\_ (Address) *Records*15 *R 10 1928* *R. J. Jones, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/2/1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar. 20*, 1928, to *Apr. 2*, 1928, that I last saw him live on *Apr. 2*, 1928, and that death occurred, on the date stated above, at *3:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*myocarditis - chronic - acute  
arteriosclerosis - general and  
cerebral*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted \_\_\_\_\_ if not at place of death? \_\_\_\_\_

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *General & Sub*(Signed) *C. J. Holmes, M. D.*  
(Address) \_\_\_\_\_

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Matthews Cem**April 2 1928*UNDERTAKER *John Lelrick*ADDRESS *2808 Orleans*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32688

## CERTIFICATE OF DEATH.

129 E 32688

1-PLACE OF DEATH

Church Home &amp; Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Cannon Street &amp; Bessie Street WARD)

2-FULL NAME

Frank E. Wood

(a) RESIDENCE NO.

1734 E. Federal

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

8 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Margaret A. Connor

6 DATE OF BIRTH (month, day, and year)

Dec 16/1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

3

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

City Water Dept

(c) Name of employer

City of Balto

9 BIRTHPLACE (city or town) (State or country)

Lancaster Co. Pa.

10 NAME OF FATHER

- Mrs. [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant (Address)

Margaret A. Wood 1734 E. Federal St.

15

Filed

C. HAYDON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 / 8 / 1928

17

I HEREBY CERTIFY, That I attended deceased from

3 / 28, 1928, to 4 / 8, 1928.

that I last saw him alive on 4 / 8, 1928.

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uterine Cancer, Renal Disease (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History &amp; Physical Findings of Frank Smith M. D.

4/8, 1928 (Address) Church Home &amp; Infirmary

\*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Carpenter's Home

4 / 11 / 1928

20 UNDERTAKER

ADDRESS 2016

Philip Henry

Clemens

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32689

## CERTIFICATE OF DEATH.

90 E 32689

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 N. Durham St.

ST. 8-17 WARD

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina M. Bregel

(a) RESIDENCE NO. 1832 N. Durham St.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced

HUSBAND of (or) WIFE of

Harry H. Bregel

6 DATE OF BIRTH (month, day, and year) May 8th. 1890

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 37 11 0

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER John Holdorf

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. MD.

12 MAIDEN NAME OF MOTHER

Fredericka Stienburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant Harry H. Bregel

(Address) 1832 N. Durham St.

15 Filed 1928 REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8/ 1928

I HEREBY CERTIFY, that I attended deceased from November 1, 1927 to April 8, 1928, that I last saw her alive on April 8, 1928, and that death occurred, on the date stated above, at 10.55A.m.

The CAUSE OF DEATH\* was as follows:

Coronary Insufficiency

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. Cardiac dilatation

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. D.

49 1928 (Address) 2025 North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cem.

DATE OF BURIAL

4/11/28

20 UNDERTAKER

Philip Herwig

ADDRESS 2016

Orleans St.



32690

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

✓ 100-001  
E 32690

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 N Mount ST., 16-22 WARD)

2-FULL NAME Hazikiah Broxton Jr

(a) RESIDENCE NO. 1031 N. Mount ST., WARD

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1926

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
1 3 14

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md

10 NAME OF FATHER Hazikiah Broxton

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) va

12 MAIDEN NAME OF MOTHER William Christian

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) va

14 Informant Hazikiah Broxton (Address) 1031 N. Mount

15 Filed PR 10 1928 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 8 19 28

17 I HEREBY CERTIFY, That I attended deceased from April 7, 19 28, to Apr 8, 19 28, that I last saw him alive on Apr 8, 19 28.

and that death occurred, on the date stated above, at 7:30 P m

The CAUSE OF DEATH\* was as follows:

Branches pneumonia  
(duration) yrs. mos. 6 ds.

CONTRIBUTORY Acute Bronchitis  
(Secondary) (duration) yrs. mos. 1 d. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? (Signed) J. McLean M. D.

(Address) 1126 Davis Ave  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

1117 3rd St DATE OF BURIAL Apr 10 1928  
UNDERTAKER Ch Brown & Son ADDRESS 1117 3rd St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32691

## CERTIFICATE OF DEATH.

100-001  
E 32691

1-PLACE OF DEATH U.S. Marine Hospital, Balto. Md.

CITY OF BALTIMORE: (No.

ST. 1-3 WARD)

2-FULL NAME Aaron Thomas

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2100 Block Aliceanne

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 8 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4, 1864

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 64 1 4

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mate

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer John W. Hoxey

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER John Brackett

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Sara Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant the deceased (Address)

15 Filed APR 10 1928 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1928

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1928, to April 8, 1928,

that I last saw him alive on April 8, 1928,

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH\* was as follows:

Osteomyelitis, chronic

unknown (duration) yrs. mos. ds.

CONTRIBUTORY Pneumonia, terminal (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death? not known

Did an operation precede death? yes Date of April 6, 1928

Was there an autopsy? yes

What test confirmed diagnosis? 1-Culture of organisms from lesion 2-X-ray examination (Signed) S. J. Hall, M. D.

19 (Address) U.S. Marine Hospital, Balto. Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Undertaker Samuel Conoley

APR 10 1928

Undertaker E. Le Roy Stiller

ADDRESS 1258 North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32692

702 E 32692

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward 17)2-FULL NAME Joseph Grubert(a) RESIDENCE NO. 1902 N. Chester St.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 22 ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

Male.

White.

Single.

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year)  
September, 17, 1926

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

1

6

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

10 NAME OF FATHER

Joseph Grubert.

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Margaret Keller.

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Hanover Pa.

14

Informant  
(Address)Joseph Gruber. (father)  
1902 N. Chester St.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 8th, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Foreign body in Trachea and Larynx.  
(Egg shell)  
Operation Tracheotomy.CONTRIBUTORY (duration) yrs. mos. ds.  
(Secondary) Edema of Glottis.(duration) yrs. mos. ds.  
(Signed) John J. H. H. H. M. D.  
(Coroner)4/9, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.  
1902 N. Chester St. April 3, 1928Former or usual residence  
19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of BurialBaltimore Cemetery April 11, 192820 UNDERTAKER ADDRESS  
George W. Gubler 1737 E. Eager St.PARENTS  
very important. See instructions on back of card.

R 10 1928

HARRISON JONES, M. D.  
Registrar

E 32693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 32693

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY ST. 8-17 WARD)

2-FULL NAME

Robert W. Terry

(a) RESIDENCE NO.

1739 E Oliver

(Usual place of abode)

ST. 8-17 WARD

Length of residence in city or town where death occurred 61 yrs. 3 mos. 7 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Louise M. Terry

7 DATE OF BIRTH (month, day, and year)

Dec 31 1866

AGE

61 Years

Months

3

Days

7

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sheet metal worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

John Terry

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ma

12 MAIDEN NAME OF MOTHER

Mary Wilkerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

LaPlata Maryland

14

Informant (Address)

John Louise M. Terry  
1739 Oliver St

15

Filed

19

HARRISON JONES, M. D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7 1928

17

I HEREBY CERTIFY, That I attended deceased from 3/30, 1928, to 4-7, 1928.

that I last saw him alive on 4-7, 1928.

and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia  
Acute & Chronic myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY Cerebral hemorrhage, with Left Hemiparesis

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Williams Bryant, M. D.  
, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

London Park April 10 1928

20 UNDERTAKER ADDRESS  
John F. Denny 715 List St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 32694

E 32694

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 802 Hampden Ward 14-20)2-FULL NAME Alice Cook(a) RESIDENCE NO. 802 Hampden St. Ward 14-20

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race Cool5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Wm H. Cook (or) WIFE of6 DATE OF BIRTH (month, day, and year) Dec 26 - 1884

7 AGE

Years

Months

Days

43 3 11

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) La

(State or country)

10 NAME OF FATHER Wm Mason11 BIRTHPLACE OF FATHER (city or town) La

(State or country)

12 MAIDEN NAME OF MOTHER Anna Jackson13 BIRTHPLACE OF MOTHER (city or town) La

(State or country)

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Informant

(Address) 802 Hampden

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Filed

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## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32695

E 32695

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 26-35 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mike Nick(a) RESIDENCE NO. 4711 Eastern ave.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos.ST. Unknown WARDds. How long in U. S., if of foreign birth? Unknown mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Unknown

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Greece  
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Greece  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Greece  
(State or country)

14

Informant. Hospital Records  
(Address)15 1928 C. HAMPTON JONES, M. D.  
File 2330 THE MORGUE.

UNIVERSITY OF MARYLAND

20 UNDERTAKER

Sanitation Health

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

ADDRESS

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1928

17

I HEREBY CERTIFY, That I attended deceased from March 17 19 28 to April 2nd 19 28.that I last saw him alive on April 2nd 19 28.and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical & Lab.(Signed) J. M. Madder M. D.4-2-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32696

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY ST. 3-5 WARD)REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Samuel Jones(a) RESIDENCE No. 1030 E. Sunland ST., 3-5 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. mos. ds.

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteWidowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) ?

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

85

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore  
Maryland10 NAME OF FATHER Peter Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York12 MAIDEN NAME OF MOTHER Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

New York

14

Informant (Address)

Deceased

15

File

HANSON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1928 to Apr 2, 1928, that I last saw him alive on Apr 2, 1928 and that death occurred, on the date stated above, at 10:00 A. M.

The CAUSE OF DEATH\* was as follows:

Demoplegia - right -  
Cerebral Demoplegia  
arteriosclerosis  
hypertension yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sub(Signed) C. J. Jones M. D.  
19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
UNIVERSITY OF MARYLAND

DATE OF BURIAL

19

20 UNDERTAKER  
Commissioner of Health

ADDRESS

APR 10 1928

E 32697

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2409 E. Biddle ST., 7-12 WARD)2-FULL NAME Clara Stone(a) RESIDENCE NO. 2409 E. Biddle

(Usual place of abode)

ST., 7-12 WARD

Length of residence in city or town where death occurred

yrs. 8 mos. 8 ds.

How long in U. S. if of foreign birth?

(If non-resident give city or town and State)

yrs. 8 mos. 8 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant6 DATE OF BIRTH (month, day, and year) Aug 18-1921

7 AGE

Years 7Months 8Days 22If LESS than 1 day, hrs. 0 min. 0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Port F. Stone11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore12 MAIDEN NAME OF MOTHER Katherine Lloyd13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14

Informant (Address) Port F. Stone

15

Filed

C. HAMPSON JONES, M. D.

Per

Registrar

10 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 19 28

17

I HEREBY CERTIFY, That I attended deceased from 1/11, 19 28, to 4/10, 19 28.that I last saw him alive on 4/9, 19 28.and that death occurred, on the date stated above, at 4154 m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis(duration) yrs. 3 mos. 0 ds.CONTRIBUTORY (Secondary) Anemia(duration) yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4/10Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hampson Jones M. D., 19 (Address) 1277 Melrose

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1203Baltimore CemeteryApril 12 1928Henry Lutz27 Broadway



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32698

## CERTIFICATE OF DEATH.

90 E 32698

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125- 11th

ST. 16-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Gustavus A. Davis

## (a) RESIDENCE NO.

125- 11th St

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

Rosalie Davis

6 DATE OF BIRTH (month, day, and year)

May 24, 1886

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41

10

14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Samuel Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Elizabeth Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Mrs Rosalie Davis 125- 11th St

15

Filed

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 8 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 7, 1928, to April 8, 1928.

that I last saw him alive on April 8, 1928.

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:

Bronchial Asthma  
Pneumonia  
Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Joseph Toubey, M. D.

19 (Address) 502 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

M. D. Davis

April 10 1928

20 UNDERTAKER

ADDRESS

W. H. Cook

502 E. North Ave

E 32699

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001 E 32699

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1009 Brantley St. 16-76 Ward)2-FULL NAME Martha W Bierbower(a) RESIDENCE NO. 1009 Brantley St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

Female White Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas E. Bierbower6 DATE OF BIRTH (month, day, and year) May 9-1854

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

73111

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

10 NAME OF FATHER Wm H. Hamilton11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address) Richard A Bierbower  
1009 Brantley St

15

Filed

C. HANSON JONES, M. D.

Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10th 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, au-

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage 3  
Atopsy  
Sudden

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Apr 10 1928 (Address)

(Coroner)

File Link M. D.  
North Ave & Division

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park April 12, 28  
Wm Coops 602 E

very important. See instructions on reverse side.

32700

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *207 E Preston* ST. *11-15* WARD)2. FULL NAME *Elizabeth M. B. Marge*(a) RESIDENCE NO. *207 E Preston*

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**Mute**Married*

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

*Mr Nelson Marge*

6 DATE OF BIRTH (month, day, and year)

*Sept 1 - 1853*

7 AGE

Years

Months *7*Days *9*

If LESS than 1 day, .... hrs. or .... min.

*14*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore**Co Md*

10 NAME OF FATHER

*Dr L. S. Gittings*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore Co Md*

12 MAIDEN NAME OF MOTHER

*W Young*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore Co Md*

14

Informant (Address)

*Mr Mutch 207 E Preston St*

15

Filed

*10-1928*

C. HAMPSON JONES, M. D.

Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 10 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*May 4, 1927, to April 10, 1928.*that I last saw him alive on *April 10, 1928.*and that death occurred, on the date stated above, at *1:25 P.M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral hardening of arteries with mural thrombosis*(duration) *2 yrs. 4 mos. 10 ds.*

CONTRIBUTORY (Secondary)

*thrombosis*(duration) .... yrs. .... mos. *10 ds.*

18 Where was disease contracted

if not at place of death? ☒Did an operation precede death? *no* Date of .....Was there an autopsy? *no*What test confirmed diagnosis? *yes*

(Signed)

*Charles B. Jones, M. D.*

(Address)

*1115 W. 19th St*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Greenmount Cem**April 11 1928*

20 UNDERTAKER

ADDRESS

*Henry Jenkins, Son Co**1115 W. 19th St*

E 32701

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32701

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Franklin Square Hosp

CITY OF BALTIMORE: (No.

Calhoun &amp; Fayette ST.

WARD)

2-FULL NAME

Peter Confas

(a) RESIDENCE NO.

426 S. 13th

(Usual place of abode)

Length of residence in city or town where death occurred

6 yrs.

mos.

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

6 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

1890  
If LESS than  
1 day, hrs.  
or min.

38

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

waiter

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Greece

10 NAME OF FATHER

Anastasis Confas

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Greece

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

Friend (Nick) Stamoulis

15

Filed

C. HAMPTON JONES, M.D.  
Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

16-37

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 7 1928

17

I HEREBY CERTIFY, That I attended deceased from  
March 24, 1928, to April 7, 1928,  
that I last saw him alive on April 7, 1928,  
and that death occurred, on the date stated above, at 7:25 P. m.  
The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach

CONTRIBUTORY (Secondary)  
(duration) yrs. mos. ds.  
Generalized metastasis18 Where was disease contracted  
if not at place of death? Home

Did an operation precede death? Yes Date of Mar 30, 1928

Was there an autopsy? No

What test confirmed diagnosis? Operation  
(Signed) Elizabeth B. Sherman, M.D.  
, 19 (Address) Franklin Square Hosp.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Woodlawn Cem

UNDERTAKER

Wendell J. Lippel

DATE OF BURIAL

April 11, 1928

ADDRESS

3008 Eden



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32702

E 32702

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1614 Hollins St* S. *19-28* Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Albert A. Burnham Jr.,*(a) RESIDENCE NO. *I6I6 Hollins St.,* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* mos. \_\_\_\_\_ ds. \_\_\_\_\_ How long in U. S. if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX \_\_\_\_\_ 4 Color or Race \_\_\_\_\_ 5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Feb. 21, 1927*7 AGE \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Days *19* IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

*Baltimore*

(State or country)

*Md.*10 NAME OF FATHER *Albert A. Burnham*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Md*12 MAIDEN NAME OF MOTHER *Emma Rider*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Md*14 Informant *Albert A. Burnham*(Address) *I6I6 Hollins St.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 10 - 28* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *Apr 8*, 19 *28*, to *Apr 10*, 19 *28*.that I last saw him alive on *Apr 9*, 19 *28*.and that death occurred, on the date stated above, at *29* m.

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia*CONTRIBUTORY (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *4* da.

(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *7* da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *None*(Signed) *H. H. Jones*, M. D.(Address) *3758*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*London Park Cemetery*

Date of Burial

*April 12, 28*

20 UNDERTAKER

ADDRESS

*Harry Smith 153*

very important. See instructions on back of certificate

10 1928

G. H. JONES, M.D.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32703

CERTIFICATE OF DEATH.

129 E 32703

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 16-68)

2-FULL NAME Henry Krumm

(a) RESIDENCE NO. 2430 W. Lafayette Ave St.      Ward     

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

white

5 Single, Married, Widowed, or Divorced, (write the word)

widower

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Ella R(Nee Claggett)

6 DATE OF BIRTH (month, day, and year)

Nov 4/1864

7 AGE

Years

Months

Days

63

5

5

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bank Teller

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER

Christian Krumm

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant  
(Address)

H. Frank Krumm

2430 W. Lafayette Ave

15 Filed

C. H. JONES

April 11, 1928

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 8/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry  
(Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Serous Meningitis-Chr. Myocarditis-Chr. Nephritis  
(Autopsy at hospital)  
(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Acute Alcoholism  
(Secondary)

(Signed)

(Coroner)

M. D.

4/10/28 (Address)

508 E. North Ave

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs. ....mos. ....ds.

In the

State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Druid Ridge Cr April 11, 28

20 UNDERTAKER

ADDRESS

Harry Witzke 1531 W. Lombard St

very important. See instructions on back of

32704

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32704

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2703 E. Fayette ST. 6-10 WARD)

2-FULL NAME Ella Zeigler

(a) RESIDENCE NO. 2703 E. Fayette  
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

ST. WARD

REGISTERED NO. 90 E 32704  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Henry E. Zeigler

DATE OF BIRTH (month, day, and year) Jan. 6, 1857

AGE Years 71 Months 3 Days 2 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indiana

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Rosa Radke  
(Address) 2703 E. Fayette

15 10-1928 REGISTRAR RTK

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/28

17 I HEREBY CERTIFY, that I attended deceased from 4-7 to 4-8 1928

that I last saw him live on 4-8 1928

and that death occurred on the date stated above, at 6:11 m.

The CAUSE OF DEATH was as follows Mental Depression

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

18 Where was disease contracted if not at place of death? Indurum

Did an operation precede death? No Date of 10

Was there an autopsy? No

What test confirmed diagnosis? See line

(Signed) Thos. P. Pugh M.D.

(Address) 800 W. Pratt St.

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL East German Lutheran Evangelical Church

20 UNDERTAKER Mrs. C. Miller & Son

DATE OF BURIAL April 11, 1928

ADDRESS 2334 York St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32705

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 6-11 Ward)2-FULL NAME George Merritt

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 104 N. Linwood St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year)

Sept 22/1919

7 AGE Years 8 Months 7 Days 17 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

## 9 BIRTHPLACE (city or town)

(State or country)

Md.10 NAME OF FATHER George Merritt

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.12 MAIDEN NAME OF MOTHER Minnie Hutchins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md14 Informant Mother  
(Address) \_\_\_\_\_

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9/28 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquiry  
(Inquest, autopsy or inquiry.)and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage-Rupture of Aneurism Post Cerebral Artery.(Autopsy at Hopkins Hospital)

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY

(Secondary)

(Signed) J. E. M. D.

(Coroner)

4/10/28 (Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Woodlawn CemeteryApril 10/28

20 UNDERTAKER

ADDRESS

Hughes & Jones Inc. 424 N. 7th

very important. See instructions on back of card.

R 1-1-1928

C. HANSSON JONES, M. D.  
Registrar



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32706

## CERTIFICATE OF DEATH.

REGISTERED NO.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 46 S. Fulton Ave. ST. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Morgan, Sr.

(a) RESIDENCE NO. 46 S. Fulton Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Laura V. Morgan

DATE OF BIRTH (month, day, and year) Jan. 4, 1852

AGE Years Months Days 4 If LESS than 1 day, hrs or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Marine Engineer

(c) Name of employer

B. C. & A. R.R.

9 BIRTHPLACE (city or town) (State or country)

Cecil Co., Md.

10 NAME OF FATHER Charles H. Morgan

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Cecil Co., Md.

12 MAIDEN NAME OF MOTHER Rebecca Robinson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant Mrs. Laura V. Morgan

(Address) 46 S. Fulton Ave.

15

Filed

19

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 8, 1928, that I last saw him alive on April 8, 1928,

and that death occurred, on the date stated above, at 07 m.

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis & Cor Pulmonale

(duration) yrs. mos. 8 ds.

CONTRIBUTORY

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician's

(Signed)

4/10/28 (Address) 1729 N. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cemetery

DATE OF BURIAL

April 11, 1928

20 UNDERTAKER

John F. Denny

ADDRESS

715 Light

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32707

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH *Franklin Square Hospital*CITY OF BALTIMORE: (No. *Calhoun & Fayette 34-33*)2-FULL NAME *David O'Dell*(a) RESIDENCE NO. *1102 Riverside Ave ST.*  
(Usual place of abode)

WARD

Length of residence in city or town where death occurred *9* yrs. *6* mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct. 8, 1918*7 AGE Years *9* Months *6* Days *2* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School boy*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md*  
(State or country)10 NAME OF FATHER *Henry O'Dell*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Seighton*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant *Mother*  
(Address) *same*15 Filed *11 1928* *HAMPSON JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 10 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 10*, 1928, to *April 10*, 1928, that I last saw him alive on *April 10*, 1928, and that death occurred, on the date stated above, at *4:40 P. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial insufficiency  
& edema of lungs and  
generalized congestion*  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? *home*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *3*(Signed) *Elizabeth Sherman* M. D.19 (Address) *Franklin Square Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Olivet Cemetery**April 13 1928*

20 UNDERTAKER

ADDRESS

*John P. Denny**715 Light St*

E 32708

## HEALTH DEPARTMENT - CITY OF BALTIMORE

## CERTIFICATE OF DEATH

36-004 E 32708  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *36-004*)

## 2-FULL NAME

(a) RESIDENCE NO. *1620 Montpelier St.*

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

*Female white single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day. hrs.  
or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

12 MAIDEN NAME

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

APR 11 1928

HARRISON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from  
3-13-28, 19, to 4-10-28, 19that I last saw her alive on 4-10-28, 19  
and that death occurred, on the date stated above, at 1130 A. m.

The CAUSE OF DEATH\* was as follows:

*Tuberculosis Both Lungs*CONTRIBUTORY  
(Secondary)

(duration) yrs. 3 mos. ds.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *Dr. Harrison Jones*

, 19

(Address) *1620 Montpelier St.*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

*John F. Denny*

ADDRESS

*715 Light St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32709

## CERTIFICATE OF DEATH.

129  
E 32709  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No 3106 E. Baltimore ST., 611 WARD)

## 2-FULL NAME

Mary A. Thompson

## (a) RESIDENCE NO.

3106 E. Balto.

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

1928

C. HAMPTON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1928

17

I HEREBY CERTIFY, That I attended deceased from Dec 21st, 1919, to April 7th, 1928, that I last saw her alive on April 7th, 1928,

and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY Arterio Sclerosis - Hypertension (Secondary) Chronic arteriosclerosis (duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Amelia V. Zimmerman, M. D.

, 19 (Address) 180 S. W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

2/11/1928  
3000 E. Balto.

J. J. Moran



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32710

1-PLACE OF DEATH

City of BALTIMORE: (No. 1906 Ashland Ave. St. 8-12 Ward)

2-FULL NAME Anna May Henninger

(a) RESIDENCE NO. 2513 E. Chase St. St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female

white

single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

1

1

2

Mar 8/1927

IF LESS than

1 day.....hrs.

or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....

none

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town)

(State or country)

Balto. Md

10 NAME OF FATHER

Edward Henninger

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto. Md

12 MAIDEN NAME OF MOTHER

Mary Heninbach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto. Md.

14

Informant  
(Address)

Mother

PR 11 1928

Filed

HAMPSON JONES, M. D.

Registrar

REGISTERED NO.

E 32710

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 Apr 10-28

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said  
(Inquest, au-  
topsy or inquiry.)inquiry and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Bronchopneumonia

(duration) .....yrs. about 4 ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner)

M. D.

Address)

4/10/28

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death.....

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

1906 Ashland

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32711

## CERTIFICATE OF DEATH

32711

### 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *216 Apple Car ST* *76-41* WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME *Anthony Marguilo*

(a) RESIDENCE NO. *216 Apple Car ST.* WARD

Length of residence in city or town where death occurred *1* yrs. *11* mos. *16* ds. How long in U. S., if foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Oct. 25, 1926*

AGE Years *1* Months *5* Days *16* If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*

10 NAME OF FATHER *Frank Marguilo*

11 BIRTHPLACE OF FATHER (city or town) *Naples* (State or country) *Italy*

12 MAIDEN NAME OF MOTHER *Fleur Balsam*

13 BIRTHPLACE OF MOTHER (city or town) *Naples* (State or country) *Italy*

Informant *Frank Marguilo* (Address) *216 Apple Car*

R 11 1928 HAYSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 10, 1928*

17 I HEREBY CERTIFY, That I attended deceased from *April 6*, 1928, to *April 10*, 1928, that I last saw him alive on *April 10*, 1928, and that death occurred, on the date stated above, at *2:25 P.* m.

The CAUSE OF DEATH\* was as follows:

*Measles*

CONTRIBUTORY (Secondary) *Broncho-pneumonia* (duration) yrs. mos. *11* ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. *5* ds.

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical Findings*

(Signed) *Vincent J. Jaska, M. D.*

19 (Address) *8457 N. Patterson PK. Bay*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Baltimore Cem* DATE OF BURIAL *Apr 11 1928*

20 UNDERTAKER *Wm. C. Crockett* ADDRESS *1906 Calhoun St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32712

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 32712

1-PLACE OF DEATH Pronounced dead at

City of BALTIMORE: (No. St. Joseph Hospital St., 9-17 Ward)2-FULL NAME Rose Ellen Smith

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 4201/2 E. Penna Ave Towson Md. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced

HUSBAND of Late Wm. Henry Smith  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 3/18557 AGE Years 75 Months 0 Days 5 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Harford Co., Md.10 NAME OF FATHER Isaah Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

"

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant Edward Hill (Grandson)(Address) 4201/2 E. Penna Ave Towson Md.

R 11 1928

C. H. HARRIS, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry find that said deceased came to her death  
topsy of inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broken Neck-Accidentally thrown  
from automobile at Joppa & Belair  
Roads.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

4/10/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION, or REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32713

## CERTIFICATE OF DEATH.

E 32713

## 1-PLACE OF DEATH

City of BALTIMORE: No. *11-15* W. Cor. Madison St Paul *11-15* Ward)2-FULL NAME *Elizabeth Dorsey Ridgely*(a) RESIDENCE No. *11-15* W. Cor. Madison St Paul *11-15* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *76* yrs. mos. ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *white* 5 Single, Married, Widowed, or Divorced. (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unborn*7 AGE Years *76* Months *—* Days *—* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Md*10 NAME OF FATHER *John Randolph Ridgely*11 BIRTHPLACE OF FATHER (city or town) *Howard Co., Md.*  
(State or country)12 MAIDEN NAME OF MOTHER *Mary Ball*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md*  
(State or country)14 Informant *Mrs Guy Stapleton*  
(Address) *229 E. Enoch Ave*15 Filed *1928* 16 *C. HAYDON JONES II* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7-10-1928*17 I HEREBY CERTIFY, That I attended deceased from *1928*, 19 *July*, 19 *27*, that I last saw him *here* alive on *July*, 19 *27*, and that death occurred, on the date stated above, at *6:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*arteriosclerosis*  
*Hypertension*

## CONTRIBUTORY

(duration) *5+* yrs. *—* mos. *—* ds. *Cerebral Hemorrhage*  
(secondary) *O. K. W. Riley M. Doctor*  
(duration) *—* yrs. *—* mos. *—* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *N.*

What test confirmed diagnosis?

(Signed) *John E. Dorsey* M. D.  
19 (Address) *129 St. Paul St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*Greenmount Cemetery April 12 1928*20 UNDERTAKER ADDRESS *Chas. G. Black 742 W. North Ave*RICE  
CORONER  
15  
REPORTED  
CASE  
THIS



E 32714

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Dinsin

## 2. FULL NAME

John Tucker

(a) RESIDENCE NO. 1700 Dinsin  
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32714

14-20 WARD

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Annie Tucker

6 DATE OF BIRTH (month, day, and year)

November 1884

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

44

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Va.

## 10 NAME OF FATHER

Sandy Tucker

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Maria Folles

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Va.

## 14

Informant  
(Address)Annie Tucker  
208 N. Preston

## 15

Filed

1928 G. HAMMON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr 8, 1928, to Apr 9, 1928,

that I last saw him alive on

Apr 9, 1928,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

William T. Ray, M. D.

4/9, 1928 (Address)

928 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Smith &amp; Case

Apr 11 1928

4000 Mosher

12276

E 32715

SLEAR  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 100-001 E 32715

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL  
CITY OF BALTIMORE: (No. 7-9 ST., Perm WARD)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2-FULL NAME John O. Slear(a) RESIDENCE NO. Winfield

(Usual place of abode)

ST. \_\_\_\_\_

WARD Perm

Length of residence in city or town where death occurred

yrs.

mos.

27

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) MarriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofHella SlearDATE OF BIRTH (month, day, and year) 2-14-58AGE Years Months Days 70 1 27 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

Perm

10 NAME OF FATHER

Charles Slear

11 BIRTHPLACE OF FATHER (city or town; State or country)

Pa

12 MAIDEN NAME OF MOTHER

Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town; State or country)

Pa

14

Informant  
(Address)Records

15

file 1928

JAMES JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar-20, 1928, to April 10, 1928, that I last saw him alive on April 11, 1928, and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Failure.CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? Winfield, Pa. (duration) yrs. mos. ds.Did an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

, 19

(Address)

James M. D.  
Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sunbury Penna4/11 1928

20 UNDERTAKER

ADDRESS

Chas. H. Evans 1180 W. Royal

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32716

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1018 N. Broadway St., 7-13 Ward)

2-FULL NAME William Waldorf

(a) RESIDENCE NO. 1018 N. Broadway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 50 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Waldorf

6 DATE OF BIRTH (month, day, and year) June 6th. 1852

7 AGE Years 75 Months 10 Days 3 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trav. Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER ----- Waldorf

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mr. J. Waldorf (Address) 1018 N. Broadway

15 Filed..... 1928

C. HAZARD JONES

90 E 32716 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9/ 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chr. Myocarditis (Angina Pectoris-history of)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) J. J. Jones (Coroner) M. D.

4/10/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Hebrew Friendship Cem.

20 UNDERTAKER

4/12/ 1928 ADDRESS

118-20 W. Mt. Royal Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32717

## CERTIFICATE OF DEATH.

90 E 32717  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 608 N. Carey St. 16-23 Ward)2-FULL NAME Lydia Preston(a) RESIDENCE NO. 608 N. Carey St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race Col5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Preston6 DATE OF BIRTH (month, day, and year) 1863

7 AGE

Years 65

Months \_\_\_\_\_

Days \_\_\_\_\_

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED Housewife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore(State or country) and10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) and12 MAIDEN NAME OF MOTHER Nancy Johnson13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) and

PARENTS

14 Informant (Address) Elizabeth Wilson  
608 N. Carey

11-1928

15 HARRISON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an \_\_\_\_\_ (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said \_\_\_\_\_ (Inquest, au-

topsy or inquiry.) and that said deceased came to \_\_\_\_\_ death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis  
(duration) \_\_\_\_\_ yrs. one mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. B. Leub

(Coroner)

(Address) with Art Wierin

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the \_\_\_\_\_ yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL mt Auburn Date of Burial 7/11/192820 UNDERTAKER Mrs. Geo. L. HollandADDRESS 1631 Duval St



E 32718

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32718  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 619 N. Bantala 16-69 Ward)2-FULL NAME Alice M. Cherry(a) RESIDENCE NO. 619 N. Bantala St. WardLength of residence in city or town where death occurred 64 yrs.

(If non-resident give city or town and State)

How long in U. S. if at foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm W. Cherry6 DATE OF BIRTH (month, day, and year) Feb 21-18647 AGE Years Months Days 64-1-20 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Levin Freeman11 BIRTHPLACE OF FATHER (city or town) Ind. (State or country)12 MAIDEN NAME OF MOTHER Sarah Hamilton13 BIRTHPLACE OF MOTHER (city or town) Ind. (State or country)14 Informant Wm W. Cherry (Address) 619 N. Bantala15 Filed 2-19-28

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10<sup>th</sup> 1928

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au- topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis (duration) 4 yrs. 7 mos. 1 ds.

## CONTRIBUTORY (Secondary)

(Signed) F. E. Smith M. D.(Address) North Ave & Wm

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial Apr 12<sup>th</sup> 192820 UNDERTAKER George Schilling Sons ADDRESS 1126 E. Mount St

very important. See instructions on reverse side.

E 32719

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32719

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3506 Hickory Lane* ST. *13-52* WARD)2-FULL NAME *Unita Frazer*(a) RESIDENCE NO. *3506 Hickory Lane* ST. *13-52* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *5* mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO. *100-001*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) *Dec 13 1927*

AGE

Years *3*

Months

Days *28*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md*10 NAME OF FATHER *William Frazer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*12 MAIDEN NAME OF MOTHER *Marian Easton*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14

Informant *William Frazer*(Address) *3506 Hickory Lane*

15

Filed *11 1928*(Signature) *JONES, H. B.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11 1928*

17

HEREBY CERTIFY, That I attended deceased from *4/11/28* to *4/11* 19 *28* that I last saw him live on *4/10* 19 *28* and that death occurred, on the date stated above, at *5:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Bio Pneumonia*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No*

Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Aspirate*(Signed) *C. T. Hughes*

4/11, 19

(Address) *2701 N. Lee St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St. Marys Hampton*DATE OF BURIAL *April 12 1928*20 UNDERTAKER *Phenowethson*ADDRESS *2701 N. Lee St.*

E 32720

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *212 S. Calhoun St.* 19-28

WARD)

REGISTERED NO. *129* E 32720

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Amie M. Widner*(a) RESIDENCE NO. *212 S. Calhoun St.*

(Usual place of abode)

WARD

Length of residence in city or town where death occurred *Life* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John W. Widner*6 DATE OF BIRTH (month, day, and year) *Aug 11, 1860*7 AGE *67* Years *8* Months *28* Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *none*9 BIRTHPLACE (city or town) (State or country) *Baltimore, Md*10 NAME OF FATHER *John W. Widner*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Eva Phillips*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *Mrs. J. H. Jones*

15

Filed *1928*

19

HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 9, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr. 1, 1928* to *April 9, 1928* that I last saw him alive on *April 9, 1928* and that death occurred, on the date stated above, at *9 P. M.* The CAUSE OF DEATH\* was as follows:*Chronic Int. Nephritis.*(duration) *1* yrs. *—* mos. *—* ds.CONTRIBUTORY (Secondary) *none*(duration) *—* yrs. *—* mos. *—* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Micro Analysis, etc.*(Signed) *J. H. Jones*

M. D.

(Address) *888 N. E. St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St Peter*

DATE OF BURIAL

*April 13, 1928*

ADDRESS

20 UNDERTAKER *John Fields 1200 N. Lombard*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32721

## CERTIFICATE OF DEATH.

X70 ✓ E 32721

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 E Monument ST., 7-9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

James J. Allen

## (a) RESIDENCE NO.

476 Ralph Ave Brooklyn N.Y.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

— yrs. —

mos. 12ds. 12

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Maggie Allen

## 6 DATE OF BIRTH (month, day, and year)

Not known

## 7 AGE

44

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Butler

## (b) General nature of industry, business, or establishment in which employed (or employer)

at home

## (c) Name of employer

Inglesal

## 9 BIRTHPLACE (city or town) (State or country)

New York N.Y.

## 10 NAME OF FATHER

Henry Allen

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

N.Y.

## 12 MAIDEN NAME OF MOTHER

Not known

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.Y.

## 14

## Informant (Address)

Merlemet Hall  
1641 E. Monument St.

## 15

## Filed

11 1928C. HARRISON JONES, D.OurRegister

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/28 19

## 17

I HEREBY CERTIFY, That I attended deceased from March 28, 1928, to April 10, 1928.that I last saw him alive on 4/8/28, 19and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH\* was as follows:

Encephalitis(duration) yrs. mos. 11 ds.

## CONTRIBUTORY (Secondary)

Scoma(duration) yrs. mos. 3 ds.18 Where was disease contracted if not at place of death? N.Y.Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none

(Signed)

4/4/28 (Address) 709 N Broadway

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

To Brooklyn New York4/11 1928

## 20 UNDERTAKER

## ADDRESS

Byron Knight 1218 McElderry St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32722

## CERTIFICATE OF DEATH

E 32722

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4110 Lloyd Ave. 28 3 Ward)2-FULL NAME Jessie C. Thompson(a) RESIDENCE NO. 4110 Lloyd Ave. 28 3 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 10 ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female WhiteSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 31, 1855

7 AGE

Years

Months

Days

If LESS than 1 day... hrs. or min..

72 5 10 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto. Md.

10 NAME OF FATHER

Wm. B. Thompson

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Mary J. DeValangin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto. Md.

14

Informant

(Address)

Francis D. Thompson  
4110 Lloyd Ave.

15 Filed

C. HAMILTON JONES II  
Registral

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 1, 1928, to April 9, 1928,that I last saw her alive on April 9, 1928,and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH\* was as follows:

Dysentery of  
Intestines(duration) yrs. 6 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Yes(Signed) F. S. Robertson M. D., 19 (Address) 719 N. D. Ave. Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

Smith Ridge Army  
John C. Mitchell & Sons 1900 Canton Pike

very important. See instructions on back of form.

## HEALTH DEPARTMENT-CITY OF BALTIMORE

32723

## CERTIFICATE OF DEATH

REGISTERED NO.

E 32723

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4904 Woodside Ave. 28-71

2-FULL NAME Maria Stull White

(a) RESIDENCE NO. 4904 Woodside Ave.

Length of residence in city or town where death occurred 60 yrs. mos. ds.

St. Ward

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day... hrs.  
or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)Kathleen M. White  
4904 Woodside Ave.

APR 11 1928 HAMILTON JONES, M.

Per Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1928

I HEREBY CERTIFY, That I attended deceased from  
April 9, 1928, to April 10, 1928,  
that I last saw her alive on April 10, 1928,  
and that death occurred, on the date stated above, at 11:20 p. m.The CAUSE OF DEATH\* was as follows:  
PneumoniaCONTRIBUTORY (duration) yrs. mos. ds.  
(Secondary) Cardiac disease18 Where was disease contracted  
(duration) 6 yrs. mos. ds.

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed)

Dr. Dureau Thomas, M. D.

1928 (Address) 410 med. Ant. Bldg.  
\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) Whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

David Ridge, Conn. April 13, 1928  
Tom Mitchell & Sons 1900 Eutaw Place

very important. See instructions on back of card.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 Wilmer St. 17-24 Ward)2-FULL NAME Barbara Watkins(a) RESIDENCE NO. 1209 Wilmer St. 17-24 WardLength of residence in city or town where death occurred 2 yrs. 2 mos. 19 (Usual place of abode) (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of X6 DATE OF BIRTH (month, day, and year) Jan 21-18277 AGE Years 1 Months 2 Days 19 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bethesda Md (State or country)10 NAME OF FATHER Jas Watkins11 BIRTHPLACE OF FATHER (city or town) Md (State or country)12 MAIDEN NAME OF MOTHER Alvina Hull13 BIRTHPLACE OF MOTHER (city or town) Bethesda Md (State or country)14 Informant Alvina Watkins (Address) 1209 Wilmer15 Filed 12 1928 H. H. H. RegistrarREGISTERED NO. 101-32724

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia (duration) yrs. mos. ds. 2

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 1 (Coroner) North Baltimore (Address) 1228

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

at place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL West Auburn Cemetery Date of Burial 4/2 192820 UNDERTAKER Thomas E. Nelson ADDRESS 1303 Pierston St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32725

## CERTIFICATE OF DEATH.

90 E 32725

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3134 Swyns Hall Pk. W. Md.)

## 2. FULL NAME

John Kavanagh

## (a) RESIDENCE

No. 3134 Swyns Hall Pk. W. Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 50 yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

W.5 Single, Married, ~~Widowed~~,  
~~or Divorced~~, (write the word)Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

June 24, 1859

## 7 AGE

Years

Months 10Days 11

If LESS than

1 day, hrs.

or min.

681019

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workRetired(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## (c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Ireland

## 10 NAME OF FATHER

Peter Kavanagh11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Ireland

## 12 MAIDEN NAME OF MOTHER

Mary Kavanagh13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Ireland

## 14

Informant  
(Address)Mrs. John Kavanagh  
3134 Swyns Hall Pk. W. Md.

## 15

Filed

1928HARRISON JOHN

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr 9 - 1928

## 17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 25, 1928 to April 9, 1928.that I last saw him on April 8, 1928.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Coronary Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Myocarditis  
Pulmonary Embolism yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clara J. Smith

M. D.

(Address)

4000 Harford Rd\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

New CathedralApril 12, 1928

## 20 UNDERTAKER

## ADDRESS

Martin J. J. J. J.1827 N. Mont



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32726

## CERTIFICATE OF DEATH

79 E 32726  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Child

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15 Filed

APR 11 1928

J. CON JONES, Jr.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

Apr - 9, 1928, to Apr 10, 1928.

that I last saw him alive on April 10, 1928.  
and that death occurred, on the date stated above, at 4:20 A.M.

The CAUSE OF DEATH\* was as follows:

Convulsions

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Boettner  
HEALTH DEPARTMENT—CITY OF BALTIMORE

32727

E 32727

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 12 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

H

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Unk

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Frostburg - Md.

10 NAME OF FATHER

Henry J. Boettner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Sophia Nagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Son in Law

15

File

PR 11 1928 HANSON JONES M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-11-1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 10, 1928, to Apr. 11, 1928,

that I last saw him alive on Apr. 11, 1928,

and that death occurred, on the date stated above, at 5:05 A.M.

The CAUSE OF DEATH\* was as follows:

Uremic Coma

Hospitalized (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Frostburg Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Walter K. Purthuer

M. D.

, 19

(Address) Union Memorial

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cumberland Md.

DATE OF BURIAL

4/14/1928

20 UNDERTAKER

Mary A. Gawthorpe

ADDRESS

2839

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32728

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 32728

CITY OF BALTIMORE: (No. *4713 Liberty Heights* *108-64* WARD)2-FULL NAME *June A. Maggio*(a) RESIDENCE No. *4713 Liberty Heights* ST.,Length of residence in city or town where death occurred *3* yrs. *9* mos. *18* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *X*6 DATE OF BIRTH (month, day, and year) *June 22-1924*7 AGE Years *3* Months *9* Days *18* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Vincent Maggio*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *June A. Mazzia*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

14

Informant (Address) *Vincent Maggio*

15

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 10 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 30*, 19 *28*, to *Apr 10*, 19 *28*that I last saw him alive on *Apr 10*, 19 *28*and that death occurred, on the date stated above, at *6.45* p.m.

The CAUSE OF DEATH\* was as follows:

*Gastro-Enteritis*(duration) yrs. mos. *12* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Regular*(Signed) *J. C. Smith* M.D.(Address) *1010 N. Y. Avenue*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Redeemer Cemetery*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Geo J Ruth 1735 Harford Ave*

## HEALTH DEPARTMENT CITY OF BALTIMORE

E 32729

## CERTIFICATE OF DEATH

REGISTERED NO.

E 32729

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *11-24* Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 ☒ Single, Married, Widowed, or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city and State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

very important. See instructions on back

PR 11 1928

H. JONES, Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32730

## CERTIFICATE OF DEATH

1-PLACE OF DEATH 3908 Woodbine Ave

City of BALTIMORE: (No. 3908 Woodbine Ave 28-64 Ward)

2-FULL NAME Josephine Evelyn Young

(a) RESIDENCE NO. 3908 Woodbine Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

September 25, 1921

7 AGE

6 Years 7 Months 17 Days 16

IF LESS than  
1 day.....hrs.  
or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Brooklyn  
New York

10 NAME OF FATHER

Earl Gordon Young

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

Texas

12 MAIDEN NAME OF MOTHER

Ellen M. Kavanaugh

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Brooklyn  
New York

14

Informant

(Address)

Earl Gordon Young  
3908 Woodbine Ave, Baltimore, Md.

15 Filed

PR 11 1928

C. HAMMON JONES, M. D.  
Registrar

E 32730

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

Apr 11

17

I HEREBY CERTIFY, That I attended deceased from

March 28, 1928, to Apr 11, 1928.

that I last saw him alive on Apr 11, 1928.

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia + Abscess of Right Lung

(duration) ..... yrs. .... mos. 21 ds.

CONTRIBUTORY

(Secondary)

Whooping Cough

(duration) ..... yrs. .... mos. 21 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Anemometer

(Signed) A. C. Smith, M. D.

(Address) 4509 G. St. N. W.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Brooklyn, New York

April 14 1928

20 UNDERTAKER

Josiah Egger

ADDRESS

1601 W. North Ave.

Baltimore, Md.

E 32731

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 32731  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 546 Osceola St. 22-30 Ward)

2-FULL NAME: Bennie Meredith

(a) RESIDENCE NO. 546 Osceola St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male Negro Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 22 - 1894

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

33

7

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Laborer

9 BIRTHPLACE (city or town)

(State or country)

Md

10 NAME OF FATHER

James Meredith

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Ida Brown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

14

Informant  
(Address)Mrs Ida Meredith  
546 Osceola St.

15

Filed

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## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry

thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Arthur J. Miller M. D.

4/9, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION, or REMOVAL

20 UNDERTAKER

Daniel Easton

Date of Burial

ADDRESS

9/6 Penn

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32732

11-092 ✓  
E 32732

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 Filed

1928

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 25, 1928, to April 10, 1928,

that I last saw her alive on April 10, 1928,

and that death occurred, on the date stated above, at 3:50 P. M.

The CAUSE OF DEATH\* was as follows:

Episodic La Grippe

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Thompson, M. D.

(Address) 19

\*State the Disease causing Death, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

2 UNDERTAKER

ADDRESS

32733

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32733

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Valley

2-FULL NAME Annie L. Mulligan

(a) RESIDENCE No. 1027 Valley Street  
(Usual place of abode)

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Mar. 27, 1884

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

44

0

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work At Home(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Baltimore

10 NAME OF FATHER Matthew Mulligan

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Byrnes

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Ireland14 Informant Miss Catherine Mulligan  
(Address) 1027 Valley Street

15

11 1928

C. H. HANCOCK, JR., M. D.  
Registrar

ST. 10-14 WARD

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)ST. WARD  
How long in U. S., If of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1928

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 3, 1928, to April 8, 1928,  
that I last saw her alive on April 8, 1928,  
and that death occurred, on the date stated above, at 2-20 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial  
nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY  
(Secondary) Uremic Coma

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual means

(Signed) Mary T. Vaughan

4-9-1928 (Address) 1028 Valley St M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Cathedral

DATE OF BURIAL

Apr. 12, 1928

ADDRESS One

20 UNDERTAKER

Bela V. Medfield, Jr. - Green



# EINOLF

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32734

## CERTIFICATE OF DEATH.

REGISTERED NO. 90 E 32734

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1820 Moreland St. 5-68 Ward)

## 2-FULL NAME Chas. Einolf

(a) RESIDENCE NO. 1820 Moreland St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs.

mos. ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Wilhelmina

6 DATE OF BIRTH (month, day, and year)

Apr 25-1848

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

78

11

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Retired

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Germany

(State or country)

10 NAME OF FATHER

John Einolf

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant  
(Address)Wilhelmina Einolf  
1820 Moreland St.

15

Filed

19

HARRISON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

192

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an

(Inquest, autopsy, or inquiry)

thereon and from the evidence obtained by said

(Inquest, au-

And that said deceased came to

death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) 3 yrs. mos. ds.

(duration) 3 yrs. mos. ds.

(duration) 3 yrs. mos. ds.

(duration) 3 yrs. mos. ds.

(duration) 3 yrs. mos. ds.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

London PK Cemetery

4/12/28

20 UNDERTAKER

ADDRESS

Geo Leimbach

545 B

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32735

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5107 Holder Ave.

Hamilton

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Grant Russell

(a) RESIDENCE. NO. 5107 Holder Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary C. Russell

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

7

0

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

P. O. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER

John Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Wilhelmina Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14

Informant (Address)

Mary C. Russell 5107 Holder Ave.

15

Died

11 1928

19

C. HAMPSON

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1928, to Apr 9, 1928, that I last saw him alive on Apr 9, 1928, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Epilepsy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

1928 (Address)

\*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bedar Hill Cemetery

April 12 1928

20 UNDERTAKER

ADDRESS

John F. Denny

715 Light St.

32736

## HEALTH DEPARTMENT—CITY OF BALTIMORE, MD. 32736

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs. 2 mos. 2 ds.

ST. 11-24 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

a If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

C. HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

3-31-1928 to

that I last saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Terminal Bronchopneumonia, Cardiac Failure

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

11, 1928 Address

\*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32737

32737

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2205 South Road* *27-54* WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

*2205 South Road ST. 27*

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male white widowed*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*George Gary Cunningham*

6 DATE OF BIRTH (month, day, and year)

*Oct. 3, 1856*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*71 6 8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Grocery Merchant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Self*9 BIRTHPLACE (city or town)  
(State or country)*Bedford Va*

10 NAME OF FATHER

*Thomas Johnston*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Scotland*

12 MAIDEN NAME OF MOTHER

*Jane Hicks*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Ireland*

14

Informant  
(Address)*Miss Sarah Johnston  
Baltimore Va.*

15

File  
1928*C. HAMPSON JONES, M. D.  
Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 11 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*May 17 1927* to *April 11 1928*  
that I last saw him alive on *April 10 1928*and that death occurred, on the date stated above, at *8:10 a m.*

The CAUSE OF DEATH\* was as follows:

*Arterio sclerosis*CONTRIBUTORY  
(Secondary)(duration) *?* yrs. mos. ds.(duration) *3* yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*William J. Todd M. D.*, 19 (Address) *111 Washington Bldg*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*London Park Cemetery**April 13 1928*

20 UNDERTAKER

ADDRESS

*Hughes Jones Inc 444 N. Bond*



E 32738

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital 26-39* ST. *Highland* WARD)2-FULL NAME *Frank Joice*(a) RESIDENCE NO. *36 North Elm St*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

110 E 32738 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Engineer Penna*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*md.*

10 NAME OF FATHER

*John Joice*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*md.*

12 MAIDEN NAME OF MOTHER

*Mary Ambrose*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*md.*

14

Informant (Address)

*B. J. Joice*

15

Filed

PR 12 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/10/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *4/6/28* 19 to *4/10/28* 19that I last saw him alive on *4/10/28* 19

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*esophageal ulcer*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed)

*H. Laurence Fahmy*

M. D.

, 19

(Address)

*St Josephs Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32739

## CERTIFICATE OF DEATH.

74 E 32739

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 W 33rd St)

ST. 13-52 WARD

### 2-FULL NAME

John Lennon

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### (a) RESIDENCE No.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Lennon

DATE OF BIRTH (month, day, and year)

April 9, 1920

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

11

27

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

md

10 NAME OF FATHER

Henry Lennon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14 Informant (Address)

Katie B. Brown

15 Filed

19

C. H. HARRIS, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 10, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 8, 1920, to April 10, 1920,

that I last saw him alive on April 9, 1920,

and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

Pulmonary edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

When test confirmed diagnosis? Examine

(Signed) J. K. Coroner, M. D.

4/11, 1920 (Address) 3427 Chestnut Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Catholic

April 13, 1920

20 UNDERTAKER

ADDRESS

Chenoweth

E 32740

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 292/ Bernard ST. 12-51 WARD)

## 2-FULL NAME Donald Leroy Michael

(a) RESIDENCE NO. 292/ Bernard

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

18 LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

H. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12 1928.

17

I HEREBY CERTIFY, That I attended deceased from 4-10 1928, to 4-12 1928.

that I last saw him alive on 4-12 1928, and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH\* was as follows:

Bro. pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

Signed

4/12/28

19 (Address)

3701 Kellard Dr

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDER TAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32741

## CERTIFICATE OF DEATH.

90 E 32741

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3924 Lloyd Ave* ST. *28-64* WARD)

2-FULL NAME *Ruth Ann Gardner*

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *3924 Lloyd Ave*

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *56* yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

If married, widowed, or divorced HUSBAND of (or) WIFE of *James W Gardner*

DATE OF BIRTH (month, day, and year) *Oct 15/1849*

AGE Years Months Days *78 5 27* If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Arcadia Carroll Co Md.* (State or country)

10 NAME OF FATHER *Jacob Miller*

11 BIRTHPLACE OF FATHER (city or town) *Arcadia Carroll Co Md.* (State or country)

12 MAIDEN NAME OF MOTHER *Elizabeth Richards*

13 BIRTHPLACE OF MOTHER (city or town) *Arcadia Carroll Co Md.* (State or country)

14 Informant *Mrs May Harker* (Address) *2218 E. Enoch Ave*

15 Filed *12 1928* C. H. JONES, M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 11 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Mar 15, 1928*, to *Apr 11, 1928*, that I last saw him alive on *Apr 10*, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*Myocarditis 3 months*

(duration) yrs. mos. ds.

CONTRIBUTORY *Active Schlemmer* (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Microscopical* (Signed) *A. C. S. M. D.*

Address *4507 S. E. Ave Hy 15*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cemetery*

*Apr 13 1928*

UNDERTAKER

ADDRESS

*Harry H. Macauley 4204 Ridgwood Ave*



E 32742

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32742

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*

CITY OF BALTIMORE: (No. *Lombard + Greene* ST. *28-63* WARD)

2-FULL NAME *Lena Thais*

(a) RESIDENCE NO. *4608 Liberty Hts Ave* ST. *28-63* WARD

(Usual place of abode)  
Length of residence in city or town where death occurred *51* yrs. *0* mos. *0* ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

If married, widowed, or divorced HUSBAND of (or) WIFE of *Herb Thais*

DATE OF BIRTH (month, day, and year) *July 29 / 1876*  
AGE *51* Years *8* Months *13* Days *13* If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*

10 NAME OF FATHER *Henry J. Brauning*

11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)

12 MAIDEN NAME OF MOTHER *Katherine Petri*

13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14 Informant *Nielsen Thais* (Address) *4608 Liberty Heights Ave.*

PR 12 1928

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11* 19 *28*

I HEREBY CERTIFY, That I attended deceased from *March 1, 1928* to *April 11, 1928*, that I last saw her alive on *April 11, 1928* and that death occurred, on the date stated above, at *3:25 P. M.*

The CAUSE OF DEATH\* was as follows:  
*Carcinoma Stomach*

CONTRIBUTORY (Secondary) (duration) yrs. *4* mos. *0* ds.

18 Where was disease contracted if not at place of death? (duration) yrs. *0* mos. *0* ds.

Did an operation precede death? *yes* Date of *March 14, 1928*

Was there an autopsy? *yes*

What test confirmed diagnosis? *Operation*

(Signed) *H. R. Kimpfmeier* M. D.

*4/11, 1928* (Address) *University Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Cathenectady N.Y.*

DATE OF BURIAL *April 14 1928*

UNDERTAKER *Harry M. Amacost*

ADDRESS *4204 Ridgemoor Ave*

12707

# HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 32743

E 32743

## CERTIFICATE OF DEATH.

32

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.

WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2. FULL NAME

Virginia Coleman

### (a) RESIDENCE NO.

1915 Wheeland

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred fit yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female white

infant

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

1-23-27

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

1

2

18

14

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None - old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Fred Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md

12 MAIDEN NAME OF MOTHER

Gladys Winter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Miled

12 1928

C. HAYDON JONES, M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 11, 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 2, 1928, to April 11, 1928

that I last saw her alive on April 11, 1928.

and that death occurred, on the date stated above, at 2:05 a. m.

The CAUSE OF DEATH\* was as follows:

Meningitis, tuberculous

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? Yes Date of April 4 1928

Was there an autopsy? No

What test confirmed diagnosis?

Exam. spinal fluid

(Signed)

J. J. Bonnett M. D.

Address

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lansdown Park

DATE OF BURIAL

4/13 1928

20 UNDERTAKER

J. J. Foley & Sons

ADDRESS

1318 Light

E 32744

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32744

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 6-9 WARD)

2-FULL NAME George Rhodes

(a) RESIDENCE NO. 1726 Mulliken ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed or divorced HUSBAND of Elizabeth Rhodes (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) 1865  
AGE Years 63 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caulker  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

PARENTS

14 Informant (Address) Reverend

15 Filed \_\_\_\_\_ 19 \_\_\_\_\_ Registrar [Signature]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/1928

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1928, to Apr. 10, 1928, that I last saw him live on Apr. 10, 1928 and that death occurred, on the date stated above, at 7:00 A m.  
The CAUSE OF DEATH\* was as follows:  
Swine and pneumonia

CONTRIBUTORY (Secondary) myocarditis, chronic (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_ (duration) 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? yes

What test confirmed diagnosis? General & Sub  
(Signed) C. Holmes, M. D.  
, 19 \_\_\_\_\_ (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Laurel Cemetery DATE OF BURIAL Apr. 14, 1928

20 UNDERTAKER Chris. H. Johnson ADDRESS 414, Caroline St.

## E 32745 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32745

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 508 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Graham(a) RESIDENCE NO. 1000 E. Fayette st.

(Usual place of abode)

ST. 508 WARDLength of residence in city or town where death occurred Unknown yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced HUSBAND of George Graham or) WIFE of6 DATE OF BIRTH (month, day, and year) 18907 AGE Years 38 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D.C. (State or country)10 NAME OF FATHER Sam Jefferson11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)12 MAIDEN NAME OF MOTHER Sara Robinson13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant Hospital Records (Address)15 Filed 19 REGISTERED Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 192817 I HEREBY CERTIFY, That I attended deceased from March 20, 19 28, to April 10, 19 28.that I last saw her alive on April 10, 19 28.and that death occurred, on the date stated above, at 5.10 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) Unknown yrs. mos. ds.CONTRIBUTORY Tuberculous kidney (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical & laboratory(Signed) H. C. Smith M. D.4-11-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

Oakbury Cemetery Apr 13 19 2820 UNDERTAKER Chas. H. Johnson ADDRESS 46 N. Caroline



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32746

## CERTIFICATE OF DEATH.

31 E 32746

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405-N. Calhoun ST. 5-23 WARD)2-FULL NAME Nathaniel Grant(a) RESIDENCE NO. 1405-N. Calhoun ST. 5-23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleColoredSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-8-1924

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.10 NAME OF FATHER Wm. Grant11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.12 MAIDEN NAME OF MOTHER Elizabeth Young13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14

Informant (Address) Marion Hawkins  
1405-N. Calhoun St.

15

Filed

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-1928

17

I HEREBY CERTIFY, That I attended deceased from 4-7- 1928, to 4-10- 1928, that I last saw him alive on 4-10- 1928, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Meningitis. T. B.From history  
Personal knowledge

yrs.

mos.

10

ds.

CONTRIBUTORY (Secondary) History  
Personal knowledge

yrs.

mos.

1

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Ruge, M. D.

19

(Address) 1816 N. Mount St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Laurel Cemetery4/13 1928

20 UNDERTAKER

ADDRESS

Thomas C. Nelson302  
Picatinet St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32747

## CERTIFICATE OF DEATH

REGISTERED NO.

32747

## 1-PLACE OF DEATH

City of BALTIMORE:

(No. 1331 W Lafayette St 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

1331 W Lafayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

Sife

yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

colored.

5 Single, Married, Widowed, or Divorced, (write the word)

married.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Ella Perkins

6 DATE OF BIRTH (month, day, and year)

Jan 18-1904

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

24

2

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chauffer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto md

(State or country)

10 NAME OF FATHER

Wm G. Perkins

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Patsy Robertson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va.

14

Informant  
(Address)Ella Perkins  
1331 W. Lafayette ave

15 Filed

10

HARISON JONES, U.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/9 1978

17

I HEREBY CERTIFY, That, I attended deceased from

Apr 1, 1978, to Apr 9, 1978

that I last saw him alive on

Apr 9, 1978

and that death occurred, on the date stated above, at

3 P. m.

The CAUSE OF DEATH\* was as follows:

Isobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

B. H. Hatcher

M. D.

(Address)

1225 Pa. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt. Auburn Cemetery

4/12 1978

20 UNDERTAKER

Thomas E. Nelson

ADDRESS

plessman

very important. See instructions on back of card.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32748

## CERTIFICATE OF DEATH.

101-001  
E 32748

## 1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital St. 2-4 Ward)2-FULL NAME John Price(a) RESIDENCE NO. 134 S. Chapel

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Helen Price

6 DATE OF BIRTH (month, day, and year)

Dec 15/1888

7 AGE

Years

Months

Days

IF LESS than

393251 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Brick Yard

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

VA

## 10 NAME OF FATHER

John Price

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant Helen Price

(Address)

134 S. Chapel St.

## 15 Filed

1928

HARRISON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

Inquiry find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Lobar)Pneumococcus Meningitis

(Autopsy)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. M. Callahan M. D.

(Coroner)

4/12/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

Evergreen Cemetery  
1735 Harford

very important - See instructions

32749

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-001  
E 32749  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 417 W. Fayette St. 16-68 Ward)

2-FULL NAME Robert Bankhead

(a) RESIDENCE NO. 2722 Laurens

St. Phila. Ward Pa.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. /ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

11-28-1928

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

53

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Ireland

10 NAME OF FATHER Robert Bankhead

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Geo. F. Rowen  
(Address) 2744 N. 5th. St. Phila. Pa.

15 Filed H. H. HARRIS, Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to his death (Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Eugene J. Zeller M. D. (Coroner)

4/11, 1928 Address 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

18 PLACE OF BURIAL, CREMATION OR Date of Burial

Phila. Pa. 4/12/28

20 UNDERTAKER Chas. J. Haws 1180 N. Royal



32750

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Sinai Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 13-20 WARD

2-FULL NAME

Ida Gottlieb Anselovitch

(a) RESIDENCE NO.

(Usual place of abode)

822 W. North Ave.

WARD

Length of residence in city or town where death occurred

32 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

32 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

F

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Gottlieb Anselovitch

DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

64

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Isidor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Isidor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Joseph P. Anselovitch 593 N. Gay St.

15

Filed

1928

H. J. M. M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 10 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 4, 1928, to April 10, 1928.

that I last saw him alive on April 10, 1928

and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage.

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Hypertension + Arteriosclerosis

(duration)

1 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Signs

(Signed)

Nilton Sherry, M. D.

4/11, 1928 (Address)

Sinai Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Rosedale

DATE OF BURIAL

4/12 1928

20 UNDERTAKER

Jack Lewis 1439 E. Baltimore

E 32751

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32751

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 101 ST., 1427 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Perman Siscorick(a) RESIDENCE NO. 1426 N Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofKate Siscorick6 DATE OF BIRTH (month, day, and year) Dec 1886

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.41 42 4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Clothing & Drimmer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant  
(Address)Kate Siscorick  
1426 N Fayette St

15

Filed

R 12 1928

H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/28 19

17

I HEREBY CERTIFY, That I attended deceased from 4/10, 1928 to 4/11, 1928, that I last saw him alive on 4/11/28, 1928, and that death occurred, on the date stated above, at 60 m.

The CAUSE OF DEATH\* was as follows:

Coronary EmbolismCONTRIBUTORY  
(Secondary)(duration) yrs. mos. 1/2 ds.(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Jones M. D.4/11/28 (Address) 375 N. Main

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Neherm Southern Ave4/13 1928

20 UNDERTAKER

ADDRESS

Jack Lewis 1409 E. 12th

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME *Ernest Perry*

(a) RESIDENCE NO. *233 Poppleton*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male*

*Colored*

*Mar -*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from *March 31, 1928* to *April 9, 1928*, that I last saw him alive on *April 9, 1928*, and that death occurred, on the date stated above, at *10:45 P. m.*

The CAUSE OF DEATH\* was as follows:

*Heart failure - acute inufficiency, myocardial failure, syphilitic aortitis*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *X-ray of heart, Wassermann*

(Signed) *Christopher Johnston*, M. D.

19 (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Joseph A. Lively 4094 Mount St*

E 32753

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32753

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Donner Hospital* ST. *14-70* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Helen Penuel White*(a) RESIDENCE NO. *1604 Franklin St. - Wilmington, Delaware.* ST. *14-70* WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. *11* ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*(a) If married, widowed, or divorced HUSBAND of (or) WIFE of *George A. White*DATE OF BIRTH (month, day, and year) *July 22, 1873*AGE *54* Years Months *8* Days *19* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Wilmington Del.* (State or country)10 NAME OF FATHER *Heran P. Penuel*11 BIRTHPLACE OF FATHER (city or town) *Susser Co.* (State or country) *Delaware*12 MAIDEN NAME OF MOTHER *Reggie*13 BIRTHPLACE OF MOTHER (city or town) *Susser Co.* (State or country) *Delaware*14 Informant *George A. White (Husband)* (Address) *1604 Franklin St. - Wilmington, Delaware*

R 12 1928 HAMILTON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 11* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *Mar 28*, 19 *28*, to *April 11*, 19 *28*, that I last saw him alive on *April 11*, 19 *28*, and that death occurred, on the date stated above, at *11:00 P. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*  
*Arrhythmic fibrillation*(duration) yrs. *6* mos. ds.CONTRIBUTORY *Arterial embolism* (Secondary)(duration) yrs. mos. *30 hours*18 Where was disease contracted if not at place of death? *Wilmington, Del.*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Electrocardiogram* (Signed) *John T. Kuig*, M. D.*Apr 7, 1928* (Address) *1208 Eutaw Pl., Balto.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Wilmington Del* DATE OF BURIAL *Apr 13, 1928*20 UNDERTAKER *Wm. J. McKner* ADDRESS *1000 North St.*



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32754

## CERTIFICATE OF DEATH.

✓  
E 32754

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 1/2 N. Saratoga ST. 4-76 WARD)

2-FULL NAME Amey Matthews (nee Sisco)

(a) RESIDENCE NO. 703 1/2 N. Saratoga ST. 4-76 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 52 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of James Sisco

DATE OF BIRTH (month, day, and year) 1876  
AGE 52 Years Months Days If LESS than 1 day, hrs or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Solomon Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Agnes Barrett (Address) 703 1/2 N. Saratoga St

15 Filed PR 12 1928 HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-1928

17 I HEREBY CERTIFY, That I attended deceased from 3/5, 1928, to 4-10, 1928, that I last saw her alive on 4-8, 1928, and that death occurred, on the date stated above, at 11:10 a m. The CAUSE OF DEATH\* was as follows:

Infective Atrial Endocarditis, ulcerative stomatitis: acute dilatation of heart (duration) 33 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical  
(Signed) W. H. Jackson, M. D.

(Address) 200 N. Arlington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR... DATE OF BURIAL

20 UNDERTAKER Samuel Handy ADDRESS 412 E. 12 St

32755

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

89 E 32755  
REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 E. North Ave ST. 15-68 WARD)

2-FULL NAME Clarence W. Bull

(a) RESIDENCE NO. 2125 E. North Ave  
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ST. WARD  
(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Ella Bull

DATE OF BIRTH (month, day, and year) Dec 9th 1866

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
61 4 2

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ret Police

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland  
(State or country)

10 NAME OF FATHER John E. Bull

11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Hampshire

13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)

14 Informant H. LEROY BULL  
(Address) 2125 E. North Ave

15 Filed 12 1928 HANCOCK JONES, M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/28 19

17 I HEREBY CERTIFY, That I attended deceased from 1/21, 1928, to 4/11, 1928, that I last saw him alive on 4/11, 1928, and that death occurred, on the date stated above, at 5:45 A. M.  
The CAUSE OF DEATH\* was as follows:  
Angina pectoris

(duration) yrs. ? mos. ? ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. P. Frank M. D.

19 (Address) 98 Biddle St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Middletown Cen Butola

Apr 13 1928

20 UNDERTAKER

ADDRESS

H. LEROY STIFFLER

125 E. North

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32756

E 32756

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

*Union Memorial Hosp.*

CITY OF BALTIMORE: (No.

*Calverton 33rd*

ST.

WARD)

2-FULL NAME

*Mr. Thomas B. Taliaferro*

(a) RESIDENCE NO.

*Tampa Fla.*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

*6* ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*married*

6 If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Stella M. Taliaferro*

7 DATE OF BIRTH (month, day, and year)

*July 19, 1859*

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*65*

*8*

*23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Banker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Virginia*

10 NAME OF FATHER

*Edmund F. Taliaferro*

11 BIRTHPLACE OF FATHER (city or town)

*Virginia*

(State or country)

12 MAIDEN NAME OF MOTHER

*Cotovia Robertson*

13 BIRTHPLACE OF MOTHER (city or town)

*Virginia*

(State or country)

14

Informant (Address)

*Mr. Taliaferro Tampa Fla.*

15

Filed

*12 1926*

*HANCOCK*

*M. D.*

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 11, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr. 11, 1928* to *Apr. 11, 1928*

that I last saw him alive on *Apr. 11, 1928*

and that death occurred, on the date stated above, at *7:20 p.m.*

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia (Bilateral)*

(duration) yrs. mos. *6* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Unknown*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Physical exam*

(Signed) *J. J. Seragelity*, M. D.

, 19 (Address) *Union Memorial Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Tampa Fla*

*April 12, 1928*

20 UNDERTAKER

ADDRESS

*Henry Jenkins, Son Co*

*Edgewood Ave. Colled. St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32757

## CERTIFICATE OF DEATH.

23 E 32757

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Calvert & 33rd St.* ST. *17-50* WARD)2-FULL NAME *Mr. Edward H. Lippington*(a) RESIDENCE NO. *3109 Belford ave*

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *49* yrs. *7* mos. *3* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Colgar Karl*DATE OF BIRTH (month, day, and year) *Sept. 8, 1879*AGE *48* Years *49* Months *7* Days *3* If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Lawyer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*10 NAME OF FATHER *Nicholas J. Lippington*11 BIRTHPLACE OF FATHER (city or town) *Bundel County*  
(State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Ellen Barker*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore*  
(State or country) *Maryland*14 Informant *Hospital Record*  
(Address) *Calvert & 33rd St.*15 Filed *1928* *C. HAMPTON JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 7*, 1928, to *April 11*, 1928, that I last saw him alive on *April 11*, 1928, and that death occurred, on the date stated above, at *3:40* p. m.

The CAUSE OF DEATH\* was as follows:

*Encephalitis Lethargica*(duration) yrs. mos. *11* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Palmer F. Williams*, M. D.*4/11, 1928* (Address) *Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*David T. Ridge Cemetery* *4/13, 1928*

20 UNDERTAKER

ADDRESS

*Henry W. Mears and Son* *805 N. Calvert*



HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 32758  
1-PLACE OF DEATH

BALTIMORE CITY HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 15-20 ST. 15-20 WARD)

2-FULL NAME Joseph Dorman

(a) RESIDENCE NO. 1564 W. Fremont Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs.  mos.  ds. How long in U. S., if of foreign birth?  yrs.  mos.  ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) ?

AGE Years 49 Months  Days  If LESS than 1 day,  hrs. or  min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Reuben Dorman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14

Informant (Address) Reverend

APR 12 1928

HARVEY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1928 to Apr. 10, 1928.

that I last saw him live on Apr. 10, 1928

and that death occurred, on the date stated above, at 5:40 A.M.

The CAUSE OF DEATH\* was as follows:

Subar pneumonia

(duration)  yrs. 9 mos.  ds.

CONTRIBUTORY (Secondary)

(duration)  yrs.  mos.  ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Subar.

(Signed) C. Stenard Boyer, M. D.

, 19  (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Anthon

APR 13 1928

UNDERTAKER

ADDRESS

Saml. Easton

916 Penna

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32759

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 10-14 Ward)2-FULL NAME Roges, Egon(a) RESIDENCE NO. 937 Stirling

(Usual place of residence)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 Color or Race C 5 Single, Married, Widowed, or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 19237 AGE Years Months Days IF LESS than  
5 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Scotland  
(State or country) N.C.10 NAME OF FATHER James Green11 BIRTHPLACE OF FATHER (city or town)  
(State or country) N.C.12 MAIDEN NAME OF MOTHER Peggie James13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) N.C.14 Informant Peggie Green  
(Address) 937 Stirling St15 Filed 1928 Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9 192817 I HEREBY CERTIFY That I took charge of the  
remains described above, held an Inquiry  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said Inquest  
(Inquest, au-  
topsy or inquiry.) find that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc  
Multiple Fractures  
(duration) yrs. mos. ds.

## CONTRIBUTORY

(duration) yrs. mos. ds.  
Signed J. C. Stiles M. D.  
(Address) 143 161 3rd\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Scotland N.C. 4/13 192820 UNDERTAKER Byron Wright ADDRESS 218 McClellerry

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32760

## CERTIFICATE OF DEATH.

31 E 32760

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *20 N. Milton Ave*)2-FULL NAME *Rosa A. Campbell*(a) RESIDENCE. NO. *20 N. Milton Ave*  
(Usual place of abode)Length of residence in city or town where death occurred *6* yrs. *0* mos. *0* ds.ST. *6-10* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD.

(If nonresident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced  
*HUSBAND* of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *June 5<sup>th</sup> 1882*7 AGE Years *45* Months *10* Days *6* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Seamstress*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Carole Ind*  
(State or country)10 NAME OF FATHER *Benjamin Laurence*11 BIRTHPLACE OF FATHER (city or town) *Ind*  
(State or country)12 MAIDEN NAME OF MOTHER *Annie Hopkins*13 BIRTHPLACE OF MOTHER (city or town) *Ind*  
(State or country)14 Informant *J. Campbell*  
(Address) *20 N. Milton Ave*15 Filed *APR 12 1928*For *Relth*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11 1928*17 I HEREBY CERTIFY, That I attended deceased from *September 15 1928* to *April 11 1928*, that I last saw him alive on *April 11 1928*, and that death occurred, on the date stated above, at *10 P* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction  
Pulmonary Tuberculosis*(duration) *2* yrs. *3* mos. *0* ds.CONTRIBUTORY (Secondary) *Myocardial Infarction*  
*Pulmonary Tuberculosis* *3* yrs. *3* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *None*

What test confirmed diagnosis?

(Signed) *Wm. G. G. G.*. 19 (Address) *156 N. Milton Ave.*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Gr. Green, Lincas arm Ind*DATE OF BURIAL *April 15 1928*20 UNDERTAKER *Shamash (Anders 1004) Residing at*

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32761

## CERTIFICATE OF DEATH

100-002  
E 32761  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1332 N. Guilman St. Ward 45-22)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Joye(a) RESIDENCE NO. 1332 N. Guilman St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 mos. 4 ds. How long in U. S. if of foreign birth? 5 yrs. 10 mos. 4 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dec 18 1926

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 1 Months 4 Days 17 IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) City10 NAME OF FATHER Ernest Joye

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country) Chas Co Md.12 MAIDEN NAME OF MOTHER Cephus Thomas

## 13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Chas Co

## 14

Informant (Address) Conrad Thomas15 Filed 12-19-28

C. H. JONES, Registrar

Per John

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11 19 2817 I HEREBY CERTIFY, That I attended deceased from Apr. 1st 19 28, to Apr 11 19 28,that I last saw him alive on April 10 19 28,and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH\* was as follows:

Bronchitis acuta(duration) 14 mos. 14 ds.

## CONTRIBUTORY

(Secondary) Myocarditis(duration) 1 yrs. 1 mos. 1 ds.

## 18 Where was disease contracted

if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Clinical methods(Signed) Geo. B. Shannon, M. D.7-18-28 (Address) 700 Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32762

## CERTIFICATE OF DEATH.

129 E 32762

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Colbert 33<sup>rd</sup>* ST. *12-44* WARD)2-FULL NAME *Mrs. Nellie Rowland Mills*(a) RESIDENCE NO. *Homewood apt- City* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *July 4 1864*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *63 9 7*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*10 NAME OF FATHER *Wm Rowland Mills*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Bekie Brown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *Mrs. G. N. McFarland Homewood apt*

15

Filed

1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 10 1928* to *April 11 1928*, that I last saw her alive on *April 11 1928*, and that death occurred, on the date stated above, at *4:15 P* m.

The CAUSE OF DEATH\* was as follows:

*Chr. Nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Myocardial failure*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Walter H. Broadbent* M. D., 19 (Address) *Livingston M. D. 1928*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Grandridge Cemetery*DATE OF BURIAL *April 14 1928*20 UNDERTAKER *John C. Mitchell & Sons 1900 Cutler Place*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 32763)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 1 mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Mar - 3, 1928, to April 11, 1928.that I last saw her alive on April 11, 1928,  
and that death occurred, on the date stated above, at 2 22 P.M.

The CAUSE OF DEATH\* was as follows:

Tuberculosis, Peritonitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed)

A. Hooper Smith, M. D.  
(Address) Johns Hopkins Hosp.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

APR 12 1928

HAYSON JONES, JR.  
RegistrarDenton, Md.  
John O. Mitchell, Sons 1900 Eutan Place

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32764

## CERTIFICATE OF DEATH

49E 32764

## 1-PLACE OF DEATH

CITY OF BALTIMORE:

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.,

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced  
HUSBAND of  
WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day,.....hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
March 21, 1928, to April 10, 1928.that I last saw him alive on April 8, 1928,  
and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of the Pancreas  
Spurred by obstruction  
of pancreas  
(duration) About 3 yrs. mos.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

PR 12 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32765

## CERTIFICATE OF DEATH.

129 E 32765

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 818 N. Bradford St. 7-12 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 15 yrs.

mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Anna Whlib

6 DATE OF BIRTH (month, day, and year)

Not known

7 AGE

Years

73

Months

-

Days

-

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Pohemia

10 NAME OF FATHER

Joseph Whlib

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pohemia

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pohemia

PARENTS

14

Informant (Address)

Anna Whlib818 N. Bradford

15

Filed

12 1928

HAYES JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928Jul 12

17

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to ..... , 19.....,

that I last saw him alive on ..... , 19.....,

and that death occurred, on the date stated above, at 3:54 m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. .... mos. .... ds.

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?..... Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) .....

, 19

(Address)

, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

Holy Redeemer

ADDRESS

Jul 16 1928Frank Garck Son1706 Calhoun



## HEALTH DEPARTMENT-CITY OF BALTIMORE

32766

32766

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

The. Gen. Hospital

REGISTERED NO.

City of BALTIMORE: (No.

Cor. E. and N. + Madison St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Silas Sponaugle

(a) RESIDENCE NO.

1819 N. Gay-

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

2/24/1911

7 AGE

Years

Months

Days

IF LESS than 1 day, hrs. or min.

17

1

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Student

9 BIRTHPLACE (city or town)

Greenbank, N. Va.

(State or country)

10 NAME OF FATHER

W. C. Sponaugle

11 BIRTHPLACE OF FATHER (City or town)

Greenbank

(State or country)

West Virginia

12 MAIDEN NAME OF MOTHER

Ella Pullin

13 BIRTHPLACE OF MOTHER (city or town)

Mill Gap

(State or country)

Virginia

14

Informant (Address)

Hospital Records

15 Filed

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

April 12 28

17

I HEREBY CERTIFY, That I attended deceased from 4-10, 1928, to 4-12, 1928.

that I last saw him alive on 4-12, 1928.

and that death occurred, on the date stated above, at 6:40 a. m.

The CAUSE OF DEATH\* was as follows:

Acute Sympathetic Autonomia

unknown (duration) yrs. mos. ds. Secondary Hemorrhage and secondary anemia (duration) yrs. mos. ds. 42

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

19

(Address)

M. D.

\*State the Disease Cause of Death, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

Date of Burial

Roanoke Va

4/13, 1928

20 UNDERTAKER

ADDRESS

George Smith 1735

32767

HEALTH DEPARTMENT—CITY OF BALTIMORE

32767

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.)

Baltimore City Hospitals

ST.

WARD)

2. FULL NAME Margaret Winkler

(a) RESIDENCE No. 326 S. 15th st.

(Usual place of abode)

Length of residence in city or town where death occurred

Unknown

yrs.

mos.

ST. 26 WARD

(If non-resident give city or town and State)

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward J. Winkler

DATE OF BIRTH (month, day, and year)

1897

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

31

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER Howard Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pennsylvania

PARENTS

14

Informant (Address)

Hospital Records

15 2 1928

C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1928

17

I HEREBY CERTIFY, That I attended deceased from April 5 1928, to April 10 1928, that I last saw her alive on April 10 1928,

and that death occurred, on the date stated above, at 3:35 a. m. The CAUSE OF DEATH was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical & Lab.

(Signed) Henry C. Smith, M. D.

4-10-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

April 10 1928

20 UNDERTAKER

Lilly & Zula Inc.

4008 W. 11th St.



32769

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1532 Graham Court Curtis Bay, Md.)

## 2-FULL NAME

Baby Ross (5 1/2 - 6 months)

(a) RESIDENCE NO. 1532 Graham Court Curtis Bay, Md.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 10<sup>th</sup> - 1928

7 AGE

Years

Months

Days

If LESS than 1 day, 1 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Curtis Bay, Md.

10 NAME OF FATHER

Henry W. Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Ethel May

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Henry W. Ross, 1532 Graham Court Curtis Bay, Md.

15

Filed

12 1928

G. HAMPTON JONES, M. D., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 10<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended the deceased from April 10<sup>th</sup> 1928 to April 10<sup>th</sup> 1928that I last saw him alive on April 10<sup>th</sup> 1928

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Premature Birth

(duration) yrs. mos. 1 hour

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Leibel, M. D.

16 1928 (Address) 1324-26 Hanover St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

Commissioner Health.

ADDRESS

APR 11 1928

Per W. E. FOELL





HEALTH DEPARTMENT—CITY OF BALTIMORE **E 32771****E 32771**

## CERTIFICATE OF DEATH.

101-001

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1157 Whatcott St. 16-22 Ward)2-FULL NAME Joe R. Hurley(a) RESIDENCE NO. 1157 Whatcott St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of X6 DATE OF BIRTH (month, day, and year) Aug 10 - 19277 AGE Years 7 Months 29 Days 30 IF LESS than 1 day...hrs. or...min.

## 8 OCCUPATION OF DECEASED

(n) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country) Apr 10 192810 NAME OF FATHER Ernest Hurley11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)12 MAIDEN NAME OF MOTHER Estella Gray13 BIRTHPLACE OF MOTHER (city or town) N.Y. (State or country)14 Informant Ernest Hurley (Address) 1157 Whatcott15 Filled \_\_\_\_\_ 19 \_\_\_\_\_ Registrar RKH

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1928

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an \_\_\_\_\_ (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said \_\_\_\_\_ (Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. B. Lusk M. D.(Coroner) John R. T. Dorman

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL \_\_\_\_\_ Date of Burial \_\_\_\_\_

20 UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

Coroner's Seal

Very Important - See

21 Filled \_\_\_\_\_ 19 \_\_\_\_\_

21928

201

Registrar

UNIVERSITY OF MARYLAND

APR 11 1928

E 32772

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 45 E 32772  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3012 Rosalind Ave ST 27-56 WARD)

### 2-FULL NAME Henry Poul

(a) RESIDENCE No. 3012 Rosalind Ave ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Anne Poul

DATE OF BIRTH (month, day, and year) Sep 1, 1869  
AGE Years 58 Months 7 Days 9 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 078  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer United R Ry

9 BIRTHPLACE (city or town, State or country) Balt Md

10 NAME OF FATHER John Poul

11 BIRTHPLACE OF FATHER (city or town, State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Jinhoff

13 BIRTHPLACE OF MOTHER (city or town, State or country) Germany

14 Informant Anna Poul (Address) 3012 Rosalind Ave

15 Filed 12 1928 Per C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 1928

17 I HEREBY CERTIFY, That I attended deceased from July 1927, to April 10, 1928, that I last saw him alive on April 10, 1928, and that death occurred, on the date stated above, at 5:10 P m.

The CAUSE OF DEATH\* was as follows:  
Abdominal Carcinoma - Primary in Spleen & Colon of Colon  
(duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 14, 1927

Was there an autopsy? No

What test confirmed diagnosis? Microscopic section (Signed) Herbert Knapp, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Druid Ridge

20 UNDERTAKER W. H. Cook

DATE OF BURIAL 4/13 1928

ADDRESS 502 E. Park Ave

32773

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

4003 Gwyn Oak St. - 64

REGISTERED NO.

32773

## 2-FULL NAME

Nellie Weems.

(a) RESIDENCE NO.

4003 Gwyn Oak St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)  
Length of residence in city or town where death occurred 56 mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Oscar Weems

6 DATE OF BIRTH (month, day, and year)

1872

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

56

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

14

Informant  
(Address)

Oscar Weems  
4003 Gwyn Oak St.

15

File

C. H. HAMILTON, J. W. H.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage  
Apoplexy  
Sudden

CONTRIBUTORY  
(Secondary)

(Signed)

Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

Lorraine  
502 E. North Ave.

Very Important. See Instructions.

12 1928



32774

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Riggs Ave. 16-22

## 2. FULL NAME

Martha Osburn

## (a) RESIDENCE NO.

1824 Riggs Ave. ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 26 mos.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White, married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles Osburn

DATE OF BIRTH (month, day, and year)

March 26/54

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

14

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

At home

9 BIRTHPLACE (city or town) (State or country)

Harrison B. C. Ohio

10 NAME OF FATHER

John Richey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Harrison B. C. Ohio

12 MAIDEN NAME OF MOTHER

Anna Gilma

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Harrison B. C. Ohio

14 Informant (Address)

Charles Osburn

15

Filed 1928, 19

WILLIAMSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 10 1928

17

I HEREBY CERTIFY, That I attended deceased from June 1925, to April 10 1928, that I last saw her alive on April 10 1928, and that death occurred, on the date stated above, at 9:00 P. M.

The CAUSE OF DEATH\* was as follows:

Cardiac Dilatation

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.

Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Wisner, M. D.

19 (Address) 4000 Edmondson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar, Ohio

DATE OF BURIAL

April 12 1928

UNDERTAKER

William Cook 202 E. Pratt St.

E 32775

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32775

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1519 Lancaster

St. 3-4 Ward)

REGISTERED NO.

2-FULL NAME TERESA SZYMANSKI,

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1519 Lancaster

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 10/28.

7 AGE

Years

Months

Days

IF LESS than 1 day..... hrs. or min..

0

0

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore,

(State or country)

MD.

10 NAME OF FATHER

Peter Szymanski,

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Poland,

12 MAIDEN NAME OF MOTHER

Sophia Zacharski,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, MD.

14

Informant (Address)

Mrs. Sophia Szymanski,  
1519 Lancaster Street

15 Filed

2 1928

C. HAMPTON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

HEREBY CERTIFY. That I attended deceased from

April 10 1928, to April 12 1928,

that I last saw him alive on April 12 1928,

and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Brown, M. D.

(Address) 800 N. Howard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

ST. STANISLAUS CEMETERY

April 13 1928.

20 UNDERTAKER

M. J. Sadowski.

ADDRESS

705 S. Union

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32776

## CERTIFICATE OF DEATH.

90 E 32776

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 407 N. Port St St., 6-10 Ward)

2-FULL NAME Frank J. Stanek

(a) RESIDENCE NO. 407 N. Port St

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Antonette Stanek

6 DATE OF BIRTH (month, day, and year)

Apr 4/18/8

7 AGE Years 50 Months 0 Days 6 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Joseph Stanek

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Austria

## 12 MAIDEN NAME OF MOTHER

Ella

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Austria

14 Informant Joseph Stanek (son)

(Address) 818 N. Lakewood Ave

15 Filed 12 1928 G. HANSON JONES, M. D.

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10<sup>1928</sup>

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry find that said deceased came to his death (topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Chr. Myocarditis

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Patton M. D.

(Coroner)

4/12/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

John Ueberich

2008 Calhoun

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32777

## CERTIFICATE OF DEATH.

185 E 32777  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2426 Jefferson St 6-10 Ward)2-FULL NAME Joseph Vogel(a) RESIDENCE NO. 2426 Jefferson St. 6-10 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Barbara Vogel6 DATE OF BIRTH (month, day, and year) Oct 31/18567 AGE Years 71 Months 5 Days 10 IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor(b) General nature of industry, business, or establishment in which employed (or employer) Butcher Shop

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.  
(State or country)10 NAME OF FATHER xxxx Vogel11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Wife  
(Address)

2 1928 C. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10-2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry find that said deceased came to his death  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broken Neck-Accidentally fell  
from clothes dryer on roof.(duration) yrs. mos. ds.  
CONTRIBUTORY Chr Myocarditis  
(Secondary)(Signed) J. H. Jones M. D.  
(Coroner)4/12/28 (Address) 608 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Parkwood Cemetery April 19 28  
20 UNDERTAKER Wm. C. Miller & Son ADDRESS 2334 Jefferson St



## HEALTH DEPARTMENT--CITY OF BALTIMORE

32778

## CERTIFICATE OF DEATH

129 E 32778  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 28 E Mt Vernon Place-15)

## 2-FULL NAME

(a) RESIDENCE NO. 28 E Mt Vernon Place

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Daniel A. Fenton

6 DATE OF BIRTH, (month, day, and year)

June 10th 1860

7 AGE

67

Years

Months

Days

IF LESS than 1 day hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

New Castle Pa

(State or country)

10 NAME OF FATHER

August Young

11 BIRTHPLACE OF FATHER (City or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

C Gerwig

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant (Address)

Barry Fenton  
28 E Mt Vernon Pl.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 10, 1928

19

17

I HEREBY CERTIFY, That I attended deceased from

July 22, 1928, to April 10, 1928.

that I last saw her alive on April 10, 1928.

and that death occurred, on the date stated above, at 12:45 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY

(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

H. K. Pettelau

M. D.

19

(Address)

817 Hamilton Ter

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park

Date of Burial

April 13 1928

20 UNDERTAKER

Henry Jenkins &amp; Sons Co

ADDRESS

very important. See instructions on back

12 1928

C. HAMMOND JONES

Registrar

32779

# HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32779

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Bellona Ave.

ST. 12-44 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Augustus Levering

(a) RESIDENCE NO. Tudor Hall Apts.

(Usual place of abode)

ST. WARD Resident

Length of residence in city or town where death occurred 78 yrs. 7 mos. 23 ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? 78 yrs. 7 mos. 23 ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine E. V. Levering

DATE OF BIRTH (month, day, and year) August-12-1849

AGE Years 76 Months 8 Days 22 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Eugene Levering

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann S. Walker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14

Informant E. Frederick A. Levering Jr., (Address) 304 Wendenover Road

15

Filed 12 1928 19 HAMILTON JONES, M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1928

17 I HEREBY CERTIFY, That I attended deceased from Dec 1-1928 to April 11 1928 that I last saw him alive on April 11 1928 and that death occurred, on the date stated above, at 4:30 P. M. The CAUSE OF DEATH\* was as follows:

Cerebral Sclerosis

CONTRIBUTORY (Secondary) Hypertensive Pneumonia (duration) 2 yrs. 4 mos. 11 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 5 ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? (Signed) Robert L. Lusk M. D. 4/11, 1928 (Address) 2112 W. Highland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL

20 UNDERTAKER STEWART & MOWEN COMPANY WILLIAM F. McRobert, Successor

April-13-28 ADDRESS

108 W. NORTH AVE.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32780

## CERTIFICATE OF DEATH.

E 32780

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed or divorced HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 (duration).....mos. ....ds.

19 (Signed)..... (Coroner) M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER ADDRESS

12 1928 C. HAMMOND JONES, M. D. Registrar

F. B. Mappert, 1850 N. Balto





32782

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32782

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Massachusetts Ave.

## 2. FULL NAME

Charles G. Rhodes

(a) RESIDENCE NO. 4000 Massachusetts Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

12 1928

19

SANDY NO. 1

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 11 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Apr 7 1928, to Apr 11 1928,  
that I last saw him alive on Apr 11 1928  
and that death occurred, on the date stated above, at 5 P m  
The CAUSE OF DEATH\* was as follows:

Bronchial asthma

(duration) 10 yrs. mos. ds.

CONTRIBUTORY Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

C. &amp; P. Hy

(Signed) Frederick T. Keenan M. D.

19 (Address) 3321 Federal Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

E 32783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 32783

1-PLACE OF DEATH

City of BALTIMORE: (No. 1908 Fleet St. St. 2-4 Ward)

2-FULL NAME **Lavera Jonczak**

(a) RESIDENCE NO. 1908 Fleet St. St. Ward

Length of residence in city or town where death occurred 32 yrs. mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

REGISTERED NO.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 60 Months Days 1868 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Housewife (c) Name of employer

9 BIRTHPLACE (city or town) Poland (State or country)

10 NAME OF FATHER Luis Lazarewicz

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Gertrud Cerman

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Casimier Jonczak (Address) 1908 Fleet St.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1928

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry. Thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Myocardial Stenosis*

CONTRIBUTORY (See 101-102) *Coronary Atherosclerosis* (duration) 1 yrs. mos. ds. (Address) 143 W. Bray

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*Holy Rosary on April 14 1928*  
UNDERTAKER *John M. Weber 401 d. Chester*

very important

112 1928 E. HAWSON JONES

32784

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32784

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 Bank St.

2-FULL NAME Richard Rozanski

(a) RESIDENCE No. 1926 Bank St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

100-001

ST. 2-4

WARD

WARD

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Jan. 2 1927

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

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### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Albert Rozanski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

South Bend Ind.

12 MAIDEN NAME OF MOTHER

Helen Ziolkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Albert Rozanski 1926 Bank St.

15

Filed

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G. HAMPTON JONES

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UNDERTAKER

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# HEALTH DEPARTMENT—CITY OF BALTIMORE

32785

## CERTIFICATE OF DEATH.

31 E 32785

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Bethel St. ST. 2-4 WARD)

2-FULL NAME Martin Mrozinski

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 602 S. Bethel St. ST. WARD (Usual place of abode)  
Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1878

AGE Years Months Days If LESS than 1 day, hrs or min. 50

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer) Labor  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Dominik Mrozinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Catherine Mrozinski (Address)

15 Filed 1920 G. HAMPTON JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 19 28

17 I HEREBY CERTIFY, That I attended deceased from March 17, 19 28, to April 9, 19 28, that I last saw him alive on April 8, 19 28, and that death occurred, on the date stated above, at 3 40 A. M.  
The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 23 ds.  
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination  
(Signed) Samuel B. Wierzbicki, M. D.  
, 19 (Address) 22 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

St. Stanislaus Cem. April 13 19 28  
UNDERTAKER ADDRESS

John M. Weber 712 N. Center



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32786

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 309-2-23 St. 12-50 Ward)2-FULL NAME James M. Barnes(a) RESIDENCE NO. 309-2-23 St. 12-50 Ward(Usual place of abode)  
Length of residence in city or town where death occurred 10 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Mary J. Barnes  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18667 AGE Years 62 Months — Days — IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md  
(State or country)10 NAME OF FATHER Geo. Barnes11 BIRTHPLACE OF FATHER (city or town) md  
(State or country)12 MAIDEN NAME OF MOTHER Emma13 BIRTHPLACE OF MOTHER (city or town) md  
(State or country)14 Informant Mary J. Barnes  
(Address) 309 2 23 St15 Filed 1928 H. J. JONES Registrar90 E 32786  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11 192817 I HEREBY CERTIFY, That I attended deceased from Mar 25, 1928, to Apr 11, 1928, that I last saw him alive on Apr 11, 1928, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Varicose Heart DiseaseCONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(duration) 1 yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. A. Johnson, M. D.19 (Address) 2329 - Guilford Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Brooks Cem. Apr 14 1928  
20 UNDERTAKER Calvert Co. Md ADDRESS 1027  
John H. Toadum Wood Hill

E 32787

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 N. Collington Avenue 7-12 WARD)

2. FULL NAME Sophia A. Danz.

(a) RESIDENCE NO. 1206 N. Collington Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)  
Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Henry P. Danz.

6 DATE OF BIRTH (month, day, and year)

7/19/1872

7 AGE

Years

Months

Days

If LESS than  
1 day... hrs  
or min.

56

8

22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER Frank Gerbes

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany

12 MAIDEN NAME OF MOTHER

Eliza Demmeke

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany14 Informant Mr. Henry P. Danz  
(Address) 1206 N. Collington Avenue

15

Filed

19

HARRISON JONES, M.

Registrar

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? life yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from  
19 to 19

that I last saw h alive on 19

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Albert H. Singmaster* M. D.  
4/24/28 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Trinity Cemetery

4/15/28

20 UNDERTAKER

ADDRESS

Albert H. Singmaster

1606 N. Chester St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32788

## CERTIFICATE OF DEATH.

90 E 32788

## 1 PLACE OF DEATH

City of BALTIMORE: (No. 100 N. Front St. 5-8 Ward)

## 2-FULL NAME

## (a) RESIDENCE NO.

100 N. Front

St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

Life

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

white

## 5 Single, Married, Widowed, or Divorced, (write the word)

wid

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

68. 74. 68

1860

1903

## 7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Balt. Md.

## 10 NAME OF FATHER

John D. Bunch

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balt.

## 12 MAIDEN NAME OF MOTHER

Elizabeth A. Callison

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balt.

## 14

Informant (Address)

Edward E. Bunch

2508 N. 1st St.

PR 13 1928

C. H. Jones, Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr. 11. 28

## 17

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Senility

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

(Signed) W. J. Hays

(Coroner)

, 19 28 (Address)

1039 Broadway

\*State the Disease Causing Death, or in deaths from Violent Cause, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Int. Carmel Cemetery

4/13/28

## 20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Harford Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32789

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital 12-50* ST. WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

48 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

G. HARRISON JONES, M. D., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 12 1928

17

I HEREBY CERTIFY, That I attended deceased from

4 - 1, 1928, to 4 - 12, 1928,

that I last saw him alive on 4 - 12, 1928,

and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis — Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. L. D'Agostino, M. D.

, 19 (Address) St. Agnes Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

13 1928

Registrar

St. Agnes Hospital, Baltimore, Md. Apr. 14, 1928  
George B. Schwab, 101 E. 1st St. Baltimore, Md.



E 32790

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *13-57*)

## 2-FULL NAME

*Marie Barnes*(a) RESIDENCE No. *1308 Weldon* Ave.

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *0* mos. *19* ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *March 25, 1926*

AGE

Years

*2*

Months

*0*

Days

*19*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore**Maryland*

10 NAME OF FATHER

*Herman Barnes*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*md.*

12 MAIDEN NAME OF MOTHER

*Mary Malachi*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*md.*

14

Informant

*Mrs. Mary Barnes*

(Address)

*1308 Weldon Ave.*

15

Filed

*13 1928**HARRY JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 13, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 12, 1928* to *April 13, 1928*.that I last saw her alive on *April 12, 1928*.and that death occurred, on the date stated above, at *5:00 a. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *no* Date ofWas there an autopsy? *yes - partial*What test confirmed diagnosis? *Clinical*

(Signed)

*J. L. Levin*

M. D.

4-13, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*Wm. H. Marshall 3539 Rd. 13*

32791

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Registered No. 32791

## 1. PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital 5-8* St. *5-8* Ward)2. FULL NAME *Baley Boy Griffin*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *1216 E. Lexington* St. *5-8* Ward

Length of residence in city or town where death occurred yrs. mos. ds. Now long in U. S. if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Black* 5-Single, Married, Widowed, or Divorced (Write the word)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) *3/27/28*7-AGE *14* yrs. *13* mos. *6* ds. If LESS than 1 day, 6 hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) *Baltimore, Md.* (State or Country)10-NAME OF FATHER *Nelson Griffin*11-BIRTHPLACE OF FATHER (city or town) *New York - N.Y.* (State or Country)12-MAIDEN NAME OF MOTHER *Mable Williams*13-BIRTHPLACE OF MOTHER (city or town) *New York - N.Y.* (State or Country)

14- (Informant) (Address)

15- *PR 13 1928* *JOHN JONES* Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *4/10/28*17- I HEREBY CERTIFY, That I attended deceased from *3/27* 19*28* to *4/10* 19*28* that I last saw him alive on *4/10* 19*28* and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH\* was as follows:

*Bronchitis - pneumonia - (Prematurity)*

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Phys. Exam.*(Signed) *Thos. R. Jones* M. D.19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL *University Hospital*

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

James Dentz

(a) RESIDENCE NO.

(Usual place of abode)

130 Palmyra Ave Dundalk, Md.

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32792

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male white

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

4-5-28

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Joseph Dentz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Evelyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed 13 1928

HAB: 13 1928 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-12-28

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1928, to April 12, 1928, that I last saw him alive on April 12, 1928, and that death occurred, on the date stated above, at 5:15 p. m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration)

yrs.

mos.

7

ds.

CONTRIBUTORY (Secondary)

Not known

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed)

Allen Blanton

M. D.

19

(Address)

The Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Redeemer

April 13, 1928

20 UNDERTAKER

Jon. J. Kerr 1564. Luzerne ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32793

## 1-PLACE OF DEATH

CITY OF BALTIMORE

## 2-FULL NAME

(a) RESIDENCE NO.

2900 Ailsa Ave ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

85 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Laura Virginia Rittenhouse

6 DATE OF BIRTH (month, day, and year)

April 10 1842

7 AGE

86

Months

0

Days

0

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired (11 yrs)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Phila

10 NAME OF FATHER

Charles Rittenhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Phila

12 MAIDEN NAME OF MOTHER

Annela Van Burk

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Allstown

14

Informant

(Address)

M. J. Albert Rittenhouse

15

Filed

1-3 1928

HAYSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 10 1928

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1928, to April 10, 1928, and that I last saw him alive on April 10, 1928, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH\* was as follows

Hypostatic Pneumonia

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. 7 ds.

Arterio Sclerosis

(duration) — yrs. — mos. — ds. (many years)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Morris B. Green

M. D.

(Address) Hamilton Baltimore Md

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cem.

DATE OF BURIAL

Apr 12 1928

20 UNDERTAKER

Wm. H. H. Hous

ADDRESS

North Pa



32794

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90  
REGISTERED NO. 32794

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1717 N. Bethel

St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Berg

(a) RESIDENCE NO. 1717 N. Bethel

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. - mos. - da. How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Paul Berg

6 DATE OF BIRTH (month, day, and year)

March 17th 1846

7 AGE

Years

Months

Days 25

IF LESS than 1 day - hrs. or min.

82

27

## 9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

13 1928

C. HAMMON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1928, to April 12, 1928

that I last saw him alive on April 11, 1928

and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

CONTRIBUTORY (Secondary)

(duration) yrs. mos. / da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

4/13, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32795

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Joseph's Hospital

CITY OF BALTIMORE: (No.

Caroline & Oliver

2-FULL NAME

Baby. Jean. Walter

(a) RESIDENCE No.

2819 Brighton St

(Usual place of abode)

Length of residence in city or town where death occurred

1/2 yrs.

mos.

ds.

ST.

WARD

(If non-resident give city or town and State)

ys.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

4/9/28

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

3

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Eugene. H. Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Elmer. S. Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt. Md.

14

Informant (Address)

Eugene B. Walter 2819 Brighton St

15

1928 G. HAMPTON JONES, M. D.

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

16-68

ST.

WARD

ST.

WARD

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/12

19 28

17

I HEREBY CERTIFY, That I attended deceased from April 9, 19 28, to April 12, 19 28.

that I last saw him alive on April 12, 19 28

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Aspiration Pneumonia

(duration)

ys.

mos.

ds.

CONTRIBUTORY (Secondary)

Cardio-Respiratory Failure

(duration)

ys.

mos.

ds.

18 Where was disease contracted if not at place of death?

at home.

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical.

(Signed)

H. Laurence Fahney, M. D.

, 19

(Address)

St. Joseph's Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Cem.

April 13, 19 28

20 UNDERTAKER

ADDRESS

Geo. J. Ruth 1735 Harford Ave.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32796

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 Northern Parkway ST. 27-42

2-FULL NAME Norman Keys

(a) RESIDENCE No. 3411 Northern Parkway ST.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

ys.

mos.

ds.

REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 31/28

AGE

Years

Months

Days

If LESS than

1 day, hrs

or min

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER William F. Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER Edna. Baberbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

William F. Keys 3411 Northern Parkway

15

Filed

16. HARMON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 31, 1928, to Apr 11, 1928,

that I last saw him alive on Apr 11, 1928

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Rapid signs

(Signed)

Chas. H. Henschel

M. D.

4/13, 1928 (Address) Maple St. - Baltimore

\*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore County

April 1928

20 UNDERTAKER

ADDRESS

George J. Rutt 1735 Harford Ave.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32797

## CERTIFICATE OF DEATH.

E 32797

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Simd Hosh 22-31* ST. *6* WARD)

### 2-FULL NAME

*Samie Finklerstein*

### (a) RESIDENCE NO.

*27 E. Hill*

(Usual place of abode)

Length of residence in city or town where death occurred

*Lifes*

mos.

ds.

How long in U. S., if of foreign birth?

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

#### SEX

*7*

#### 4 COLOR OR RACE

*m*

#### 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

#### DATE OF BIRTH (month, day, and year)

*Jan. 6 - 1918*

#### AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*10*

*3*

*9*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

### 10 NAME OF FATHER

*Jacob Finklerstein*

### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia*

### 12 MAIDEN NAME OF MOTHER

*Sarah Rosenberg*

### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Russia*

### 14

Informant (Address)

*1000 Record*

### 15

Filed

19

*CHAMBERLAIN, H.*

Registrar

### MEDICAL CERTIFICATE OF DEATH

### 16 DATE OF DEATH (month, day, and year)

*Apr 13 1928*

### 17

I HEREBY CERTIFY, That I attended deceased from *March 15*, 1928, to *April 13*, 1928, that I last saw her alive on *April 13*, 1928, and that death occurred, on the date stated above, at *6 A* m.

The CAUSE OF DEATH was as follows:

*Myocardial Infarction*

(duration) yrs. mos. 3 ds.

### CONTRIBUTORY (Secondary)

*General Pentonitis*

(duration) yrs. mos. 27 ds.

### 18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *4/10/28*

Was there an autopsy? *yes* Date of *4/17/28*

What test confirmed diagnosis? *Ex. plates*

(Signed)

*Philip A. Jones, M. D.*

19 (Address) *Shuman Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Mehren Herrin Rm*

### DATE OF BURIAL

*10/13 1928*

### 20 UNDERTAKER

*Jack Lewis 1439 E. B. Ave.*



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32798

32798

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Sinai Hospital*CITY OF BALTIMORE: (No. *27-56*)2-FULL NAME *Abraham Solinsky*(a) RESIDENCE NO. *Beverden & Green Spring Ave.*

(Usual place of abode)

Length of residence in city or town where death occurred *7* yrs. *0* mos. *0* ds.WARD *40*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*a If married, widowed, or divorced HUSBAND of (or) WIFE of *Goldie Solinsky*DATE OF BIRTH (month, day, and year) *4-10-1928*AGE *68* Years *58* Months *0* Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Joseph Solinsky*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Sara*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*14 Informant *Simon Solinsky* (Address) *238 14th St New York*15 Filed *1928* *HA* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-12-1928*

17

I HEREBY CERTIFY, That I attended deceased from *4-10*, 19 *28*, to *4-12*, 19 *28*.that I last saw him alive on *4-12*, 19 *28*and that death occurred, on the date stated above, at *106* m.

The CAUSE OF DEATH\* was as follows:

*Bant's disease*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *none*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *M. D.*, 19 (Address) *Sinai Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Mehreen Herrin Rm*DATE OF BURIAL *4/13/28*20 UNDERTAKER *Jack Lewis 1437 E. Balt*

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32799

## CERTIFICATE OF DEATH

74-001  
E 32799

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1007 N. Washington St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Adelhardt(a) RESIDENCE NO. 1007 N. Washington St. 7-13 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S. if of foreign birth 44 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Anna D. Adelhardt (or) WIFE of Anna D. Adelhardt6 DATE OF BIRTH (month, day, and year) April 9 18587 AGE Years 70 Months - Days 3 IF LESS than 1 day - hrs. or - min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Street Paver  
(b) General nature of industry, business, or establishment in which employed (or employer) United Railway  
(c) Name of employer 0789 BIRTHPLACE (city or town) Germany  
(State or country)10 NAME OF FATHER Andrew Adelhardt11 BIRTHPLACE OF FATHER (City or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town) Not known  
(State or country)14 Informant Mrs. Anna D. Adelhardt  
(Address) 1007 N. Washington St.15 Filed C. H. Jones, Jr., M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 192817 I HEREBY CERTIFY, That I attended deceased from Apr 11 1928, to Apr 12 1928, that I last saw him alive on Apr 11 1928, and that death occurred, on the date stated above, at 12:15 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral HemorrhageRight HemiplegiaCONTRIBUTORY Arteriosclerosis  
(Secondary)(duration) - yrs. - mos. - ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? - Date of -Was there an autopsy? -What test confirmed diagnosis? -(Signed) Walter W. White, M. D.4/12 1928 (Address) 2855 S. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Apr 14 192820 UNDERTAKER Henry Hochman ADDRESS 13018 Eager St.

Very Important. See Instructions

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32800

## CERTIFICATE OF DEATH.

66 E 32800  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital* ST. *9-17* WARD)

## 2-FULL NAME

*Patrick Gorman*

## (a) RESIDENCE NO.

*Unknown*

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred *25* yrs. mos.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? *30* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Male**White**Unknown*

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Unknown*

DATE OF BIRTH (month, day, and year)

*1898**Age*  
*30*

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Unknown*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Ireland*

## 10 NAME OF FATHER

*James Gorman*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Ireland*

## 12 MAIDEN NAME OF MOTHER

*Ellen Nolan*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ireland*

14

Informant  
(Address)*J. A. Driscoll  
Lynn Mass*

15

Filed

*1928*  
*H. H. Jones*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/12/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*4/12/28*, 19, to *4/12/28*, 19,that I last saw him alive on *4/12/28*, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*Delirium tremens  
acute alcoholism*

(duration) yrs. mos. ds.

CONTRIBUTORY *cardiac dilatation*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Lammie Fahney*, M. D., 19 (Address) *St Joseph Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Lynn Mass*

DATE OF BURIAL

*4/13 1928*

20 UNDERTAKER

*J. H. Barton*

ADDRESS

*Heath*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32801

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward 24-34)2-FULL NAME Alfred Hemling.(a) RESIDENCE NO. 1530 Boyle St.

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 7 mos. 30 ds.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

REGISTERED NO. \_\_\_\_\_

E 32801

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male.

White.

Widower.

6a If ~~Married~~, widowed, ~~Married~~  
HUSBAND of  
~~XXXXXXXX~~Bertha Hemling.

6 DATE OF BIRTH (month, day, and year)

August 12, 1868.

7 AGE

Years

Months

Days

IF LESS than

59730

I day.....hrs.

or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

Woodworker

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

John Hemling.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pennsylvania.

## 12 MAIDEN NAME OF MOTHER

Bridget Dacey.

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland.

14

Informant Alfred J. Hemling. (son)  
(Address) 1530 Boyle St.

15

Filed 13 1928 U. S. DEPT. OF HEALTH  
JOHN M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 11, 1928

17

I HEREBY CERTIFY, That I, took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiryfind that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular disease of the Heart.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) Chas. L. Stearns

(Coroner)

4/12/28 (Address)

1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

In the

of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Light & Cross St. April 11, 1928

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Cross, A. A. Co.April 14, 1928

## 20 UNDERTAKER

Chas. L. Stearns

ADDRESS

1501 E. Fort St.



E 32802

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32802

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *408 S Vincent* ST. *19-28*)2-FULL NAME *Rose Marie Stevens*(Residence in Baltimore: No. *408 S Vincent* St.; yrs., mos., ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*female*

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

*June 11, 1867*

(Month)

(Day)

(Year)

7-AGE,

*60 yrs., 10 mos., no ds.*

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *housework*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *reb.*10-NAME OF FATHER, *David Pommer*11-BIRTHPLACE OF FATHER (State or Country), *reb.*12-MAIDEN NAME OF MOTHER *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *reb.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Barry*(Address) *1606 col. st.*

15-

PR 13 1928

C. HAMPTON JONES,

Filed

1928

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*April 11, 1928*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 7, 1928*, to *April 11, 1928*, that I saw her alive on *April 10, 1928*, and that death occurred, on the date stated above, at *4:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Paraplegia*

CONTRIBUTORY (Secondary)

(Duration) *no yrs., no mos., 4 ds.*(Signed) *Richard S. Jones* M. D.*April 11, 1928* (Address) *Lupland*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park*

DATE OF BURIAL,

*Apr. 13, 1928*

20-UNDERTAKER

*Harry H. Witzke* ADDRESS *1531 W. Lombard*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32803

## CERTIFICATE OF DEATH.

Registered No. 129 E 32803

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1314 Druid Hill Ave. Ward)

2-FULL NAME. Eliza Rich

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1314 Druid Hill Ave. St. Ward

Length of residence in city or town where death occurred 25 yrs. mos. ds. (if non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX, Female 4-COLOR OR RACE, Colored 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1863

7-AGE, 65 If LESS than 1 day, yrs. mos. ds. hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Lancaster Pa.

10-NAME OF FATHER, Cassick Montague

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Mary Jane Morgan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Dr. Jones

(Address) 1314 Druid Hill Ave.

15- C. HARRISON JONES, M. D.

Filed 13 1928

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 9-1928

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1928, to April 9, 1928.

that I last saw him alive on April 8, 1928.

and that death occurred, on the date stated above, at 8:10 p. m.

The CAUSE OF DEATH\* was as follows:

Nephritis interstitial

(Duration) 3 mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C. Stewart, M. D.

4/13, 1928 (Address) 704 W. Lafayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Vernon

DATE OF BURIAL, 4/13/28

20-UNDERTAKER, Anna Hensley

ADDRESS, 1218 St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32804

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE

## 2-FULL NAME

(a) RESIDENCE NO.

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 Filed

1928

HARRISON JONES, M. D.

Registrar

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acc Drowning

CONTRIBUTORY  
(Primary)

(Secondary)

(Tertiary)

(Quaternary)

(Quinary)

(Sextary)

(Septary)

(Octary)

(Nonary)

(Decary)

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(

REGISTERED NO.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 2017 Jankl St. 2-4 Ward 4)

2-FULL NAME Donnicka Schlusser.

(a) RESIDENCE NO. 2017, Yank.

Length of residence in city or town where death occurred 19 yrs.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)  
long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word)

3a/ If married, widowed or divorced  
HUSBAND of ~~XXXXXX~~  
(or) WIFE of ~~XXXXXX~~

6 DATE OF BIRTH *March 28-1842*  
7 AGE

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	86	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. *Reggie Retired*

(b) General nature of industry, business, or establishment in which employed (or employer). *086*

(c) Name of employer

9 BIRTHPLACE (city or town) .....  
(State or country) *Balt Md*

10 NAME OF FATHER Henry Schlosser

11 BIRTHPLACE OF FATHER (city or town).  
(State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Germany*

14 Informant Anna Barrow  
(Address) 2017 Bank St

15 Filed..... 11-11-1964

**CORONER'S CERTIFICATE OF DEATH**  
**OF DEATH**

16 DATE OF DEATH (month, day, and year) 1982

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an Inquest  
(Inquest, autopsy or inquiry.)  
(thereon and from the evidence

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.  
Inquiry and that said deceased came to his death  
 on the day stated above.  
 The 0 day of 19

The CAUSE OF DEATH was as follows:

toberio Scherensis

CONTRIBUTORY (Secondary) *by Landon* ..... mos. .... ds

Apr 11/18 (Signed) G. C. Pades (Paragon) 11/18 (Address) 11/18 (Corner) 11/18 (M. D.)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death!.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR ~~REMOVAL~~ DATE OF BURIAL

Clarkson Cemetery 4/14/28

20 UNDERTAKER  
William Cook  
ADDRESS  
507 E. North



# HEALTH DEPARTMENT—CITY OF BALTIMORE

32806

## CERTIFICATE OF DEATH.

179 E 32806

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3221 Berkshire Rd. ST. 179 E 32806 WARD)

2-FULL NAME Anne C. Shargo

(a) RESIDENCE NO. 3221 Berkshire Rd. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of William C. Shargo

DATE OF BIRTH (month, day, and year) Apr 3, 1860

AGE Years 68 Months 1 Days 8 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balt Md

10 NAME OF FATHER William Groom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant William C. Shargo (Address) 3221 Berkshire

15 Filed 1928 H. H. Mc Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11 1928

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1928, to Apr 11, 1928, that I last saw her alive on Apr 11, 1928, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Angina pectoris

(duration) yrs. mos. ds. 1

CONTRIBUTORY (Secondary) Arterio sclerosis chr. nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Jones M. D. 4/12, 1928 (Address) 720 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Graves Mount

DATE OF BURIAL

Apr 13 1928

20 UNDERTAKER

J. M. Cook

ADDRESS

502 E. North Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32807

## CERTIFICATE OF DEATH.

E 32807

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *91 Columbia Av.* ST. *16-42* WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles E. Lambdin*

(a) RESIDENCE NO. *91 Columbia Av.* ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred *66* yrs. *10* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

If married, widowed, or divorced HUSBAND of or WIFE of *Florence G. Lambdin*

DATE OF BIRTH (month, day, and year) *Jan 1861*

AGE Years Months Days If LESS than 1 day, hrs. or min. *66 10*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Interior Decorator*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Benson Co.*

BIRTHPLACE (city or town) *md* (State or country)

10 NAME OF FATHER *Wm Lambdin*

11 BIRTHPLACE OF FATHER (city or town) *md* (State or country)

12 MAIDEN NAME OF MOTHER *Mary Bowles*

13 BIRTHPLACE OF MOTHER (city or town) *md* (State or country)

PARENTS

14 Informant *Florence G. Lambdin* (Address) *91 Columbia Av.*

15 Filed *May 11 1928* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/11* 19 *28*

17 I HEREBY CERTIFY, That I attended deceased from *Jan 1st*, 19*28*, to *April 11*, 19*28*, that I last saw him alive on *April 10*, 19*28*, and that death occurred, on the date stated above, at *2:30* p. m. The CAUSE OF DEATH\* was as follows:

*Carcinoma of stomach*

(duration) yrs. *4* mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis *X-ray & physical signs*

(Signed) *Edw H Benson* M. D.

*4/12* 19*28* (Address) *Overlea Md.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*12th Cemetery*

*April 11 1928*

20 UNDERTAKER

ADDRESS

*Wm Carr 5026 Xanadu*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32808

## CERTIFICATE OF DEATH.

90 E 32808

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* 12-50 WARD)

2-FULL NAME *Mary Lida Jones*

(a) RESIDENCE NO. *2430 St Paul* ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *June 30 1865*

AGE Years *62* Months *9* Days *13* If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Maryland*

10 NAME OF FATHER *Dr. R. E. Jones*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md*

12 MAIDEN NAME OF MOTHER *Eloise Dorsey*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14 Informant *Margaret B Dorsey* (Address) *2430 St Paul St*

15 Filed *79* Registrar *K. Mc*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/13/28* 19

17 I HEREBY CERTIFY, That I attended deceased from *4/11/28*, 19, to *4/13/28*, 19, that I last saw her alive on *4/12/28*, 19, and that death occurred, on the date stated above, at *1:50 A* m.

The CAUSE OF DEATH\* was as follows:

*chronic myocarditis with auricular fibrillation*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *anemia*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Chronic*  
(Signed) *H. Lawrence Fahmy*, M. D.

, 19 (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
*London Park*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Wm Cook*

*502 E St*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32809

## CERTIFICATE OF DEATH.

31 E 32809  
REGISTERED NO.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Asquith ST. 10-14 WARD)

### 2-FULL NAME

(a) RESIDENCE NO. 930 Asquith ST., 10-14 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds.

How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of None

DATE OF BIRTH (month, day, and year) 9-15-21

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min. 7 6 12

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Geo. York

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Adella Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14

Informant (Address) Geo. York  
930 Asquith

15

Filed

S. HANCOCK JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12 19 28

17

I HEREBY CERTIFY, That I attended deceased from 4-3, 19 28, to 4/12, 19 28.

that I last saw her alive on 4/11, 19 28.

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH was as follows:

Acute Fulminating Consumption and Rickets

(duration) yrs. 7 mos. 20 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis Signs & Symptoms

(Signed) John B. Blake, M. D.

(Address) 924 Asquith

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Asbury Cem

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John W. Skinner 1625 E. Madison



E 32810

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32810

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4325 Harford Ave ST. 76-41 WARD)

2-FULL NAME Anna E. Housman

(a) RESIDENCE NO. 4325 Harford Ave  
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 36 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

If married, widowed, or divorced HUSBAND or  
(or) WIFE of late Henry H. Housman

DATE OF BIRTH (month, day, and year) Aug 19/59  
AGE Years 68 Months 7 Days 22 11 LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Pierson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry H. Housman  
(Address) 4325 Harford Ave

15 Filed 13 1928 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11 1928

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1926, to March 11, 1928, that I last saw her alive on March 10, 1928, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH\* was as follows:  
Chronic myocarditis

(duration) 4 yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. L. Gandy M. D.

4-12-1928 (Address) 4218 Harford Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London PK

DATE OF BURIAL 4/16 1928  
ADDRESS

20 UNDERTAKER Phil Herring 2016 Orleans

32811

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-001 E 32811 ✓

### 1. PLACE OF DEATH

CITY OF BALTIMORE: No. *St Agnes Hospital 25-12*

### 2. FULL NAME

*Mary E. Walsh*

### (a) RESIDENCE NO.

(Usual place of abode)

*15 Union Ave*

ST.

WARD

Length of residence in city or town where death occurred *10* yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

ys. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White*

*Single*

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*July 1, 1897*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*30*

*9*

*12*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Nurse*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Thomas P. Walsh*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*England*

12 MAIDEN NAME OF MOTHER

*Alice Richards*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Cleveland*

14

Informant (Address)

*Mary Walsh 15 Union Ave*

15

3 1928

*C. HAMPTON JONES, M. D.*

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-12* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *4-5* 19 *28*, to *4-12* 19 *28*,

that I last saw him alive on *4-12* 19 *28*

and that death occurred, on the date stated above, at *4.10 a.* m.

The CAUSE OF DEATH\* was as follows:

*Influenza - Pneumonia*

(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Francis J. Balaghiacca, M. D.*

. 19 (Address) *St Agnes' Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Easton Md.*

20 UNDERTAKER

*April 15 1928*

*M. D. & Sons*

*1827 N. North*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32812

## CERTIFICATE OF DEATH.

113 E 32812

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3901 Orleans St., Ex Ward)2-FULL NAME Viola Bach(a) RESIDENCE NO. 3901 Orleans St. Ex Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? Life yrs. mos. ds.

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Nov 20-1927

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

413

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Baltimore(State or country) Ind.10 NAME OF FATHER Frank Bach11 BIRTHPLACE OF FATHER (city or town) Baltimore Ind.

(State or country)

12 MAIDEN NAME OF MOTHER Rose Becke13 BIRTHPLACE OF MOTHER (city or town) Baltimore Ind.

(State or country)

14

Informant

(Address) Frank Bach3901 Orleans St

3 1928

C. HAMPTON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, Autopsy or Inquiry.

I received and from the evidence obtained by said Inquest, Autopsy or Inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Intestinal Pickets

CONTRIBUTORY

(Cause)

April 2

(Signed)

19

(Address)

143 N. Bury

(duration) yrs. mos. ds.

7

(duration) yrs. mos. ds.

1

(Coroner)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds.

In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence: \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

1st Sec from Lutheran Ch.April 13 1928

20 UNDERTAKER

Mrs. C. Miller2354 Jefferson

32813

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32813

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *254 Oread Ave*)2-FULL NAME *Josephine Cocilovo*(a) RESIDENCE No. *254 Oread Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *23* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced. (Write the word)*Female white**Widowed*

If married, widowed, or divorced

(or) WIFE of

*Salvatore Cocilovo*DATE OF BIRTH (month, day, and year) *July 4 - 1855*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*73*

## OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER *Francesco Mascheri*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant

(Address)

*Francesco Cocilovo*  
*254 Oread Ave*

15

Filed

*3 1928**C. HARRISON JONES, M. D.*  
*Registral*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 12 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 7 1928* to *Apr 12 1928*  
that I last saw her alive on *Apr 12 1928*

and that death occurred, on the date stated above, at

*4 P. m.*

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Luigi S. Di Stefano* M. D.*Apr 12 1928* (Address) *4407 N. Euter*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Holy Redeemer**4/14 1928*

20 UNDERTAKER

ADDRESS

*Wm Cook**502 E. N. B.*



32814

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.   
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Baltimore Street 8-16* ST. WARD)

2-FULL NAME *Baby Weinbach*

(a) RESIDENCE NO. *West Baltimore Street 8-16* ST. WARD

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *F* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *4/12/28* AGE Years Months Days If LESS than 1 day, hrs. or min. *4 2*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *FOU* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

BIRTHPLACE (city or town) *Baltimore* (State or country) *Md*

10 NAME OF FATHER *Ray Weinbach*

11 BIRTHPLACE OF FATHER (city or town) *Canada* (State or country)

12 MAIDEN NAME OF MOTHER *Eugenie Haysen*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)

14 Informant (Address) *Hospital Record.*

15 *1928* *C. HAMPTON JONES, M. D.* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-13 1928*

17 I HEREBY CERTIFY, That I attended deceased from *4/11/28* to *4/13/28*, that I last saw him alive on *4/13/28*, and that death occurred, on the date stated above, at *4/13/28* m. The CAUSE OF DEATH\* was as follows:

*Congenital anemia*

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) *premature infant (7 months)* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Chemical signs*

(Signed) *J. C. Fellner*, M. D.

, 19 (Address) *1012 R. 10*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT *St. V. de la Ville*

DATE OF BURIAL *4-14 1928*

UNDERTAKER *McCluskey & G. Rohrer*

ADDRESS *3327 E. ...*

E 32815

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32815

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hosp. 4-25* ST. *WARD*)2. FULL NAME *Baby Boy Luminello*(a) RESIDENCE NO. *662 W. Saratoga ST.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds. *How long in U. S., if of foreign birth?*

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Italian**Infant*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 11 '28*

7 AGE

Years

Months

Days

If LESS than 1 day, 10 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Maryland*10 NAME OF FATHER *Carmelo Luminello*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *Rose Imbraglio*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

14

Informant (Address) *Rose Luminello 662 W. Saratoga ST.*

3 1928

2353

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 12 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 11, 1928* to *April 12, 1928*.that I last saw him alive on *April 12, 1928*.and that death occurred, on the date stated above, at *12:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Prematurity*CONTRIBUTORY (Secondary) *Maternal-Placenta* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? Date of

Was there an autopsy? *No*What test confirmed diagnosis? *appt*(Signed) *Luigi S. Di Stefano, M.D.*1928 (Address) *6407 N. E. Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

Commissioner Health.

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32816

E 32816

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *829 Ostend*)ST. *21-24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Baby Girl Brown*(a) RESIDENCE No. *829 Ostend*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female Black*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *April 12/28*

7 AGE

Years

Months

Days

If LESS than  
1 day..... hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town) *Balto Md.*  
(State or country)10 NAME OF FATHER *Sammy Miller*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Balto Md.*12 MAIDEN NAME OF MOTHER *Violet Brown*13 BIRTHPLACE OF MOTHER (city or town) *Balto Md.*  
(State or country)

14

Informant  
(Address)

15

Filed

19

G. HAMPSON JONES, M. D.

Registrar

2354

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 12 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*April 12*, 1928, to *April 12*, 1928,  
that I last saw him alive on *April 12*, 1928,  
and that death occurred, on the date stated above, at *5 a m.*

The CAUSE OF DEATH\* was as follows:

*Congenital Atelectasis  
Maternal Syphilis.*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Phys exam*(Signed) *Freight H. Reynolds*

M. D.

, 19

(Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

*Commissioner Health.*

APR 12 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32817

## CERTIFICATE OF DEATH.

185 E 32817

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mary Hosp St., 3-5 Ward)2-FULL NAME Bernard Hawley(a) RESIDENCE NO. 924 Wilson St., \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 Color or Race white5 Single, Married, Widowed,  
or Divorced, (write the word) ?5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3, 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest  
(Inquest, au-topsy or inquiry.) and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probable heart spasm  
while intoxicated 2-3 days  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)(Signed) W. J. P. P. P.

, 19

(Address)

(duration) yrs. mos. ds.

(Coroner) M. D.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER  
Commissioner Health.

ADDRESS

1928

19 HARRISON JONES, M. D.  
Registrar

PUBLIC CEMETERY

APR 13 1928



32818

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32818

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 70-37 WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

2-FULL NAME Samuel J. Jemmy  
 (a) RESIDENCE NO. Washington, D.C. ST. \_\_\_\_\_ WARD \_\_\_\_\_  
 (Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
 (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE Colored 5 Single, Married, Widowed,  
 or Divorced, (write the word) Widowed

If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) 5

AGE Years Months Days If LESS than  
60 1 day... hrs.  
 or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
 particular kind of work Salvage

(b) General nature of industry,  
 business, or establishment in  
 which employed (or employer) 040

(c) Name of employer

BIRTHPLACE (city or town) Washington  
 (State or country) D.C.

10 NAME OF FATHER Alexander Jemmy

11 BIRTHPLACE OF FATHER (city or town)  
 (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)  
 (State or country) ?

14 Informant Reverend  
 (Address)

15 Filed 13 1928 19 2358 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9/1928

17 I HEREBY CERTIFY, That I attended deceased from  
Dec. 29, 1923, to Apr. 9, 1928  
 that I last saw him alive on Apr. 9, 1928  
 and that death occurred, on the date stated above, at 7:30 P. M.  
 The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis  
to carcinoma

(duration) ? yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted ?  
 if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? General & Sub  
 (Signed) C. J. Jemmy M. D.  
 , 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

## 20 UNDERTAKER

19

ADDRESS

32819

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32819

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3053 Gifford Ave* ST. *17-50* WARD)2-FULL NAME *Octavious M. Reldin*(a) RESIDENCE No. *3053 Gifford Ave* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *55* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*If married, widowed, or divorced HUSBAND of (or) WIFE of *Ann E. M. Reldin*DATE OF BIRTH (month, day, and year) *July 25 1848*  
AGE Years Months Days *79* *8* *19* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Watchman*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.* (State or country)10 NAME OF FATHER *Samuel M. Reldin*11 BIRTHPLACE OF FATHER (city or town) *Baltimore Md.* (State or country)12 MAIDEN NAME OF MOTHER *Frances Taylor*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md.* (State or country)14 Informant *Wm. H. Vagengast* (Address) *3053 Gifford Ave*15 *3-1828* 19 *APR 1928* Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 12 1928*17 I HEREBY CERTIFY, That I attended deceased from *Sept 12*, 1926, to *April 12*, 1928, that I last saw him alive on *April 10*, 1928, and that death occurred, on the date stated above, at *5:30* A. M.  
The CAUSE OF DEATH\* was as follows:*Chronic Intestinal Affection*CONTRIBUTORY (Secondary) *Myocardial Infarction* (duration) *3* yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Symptoms*  
Signed *Edw. J. Benson* M. D.  
4/13, 1928 (Address) *Owden Md.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Louisa Park Cemetery* DATE OF BURIAL *April 14 1928*20 UNDERTAKER *Robt. Turner* ADDRESS *1042 Broadway*

E 32820

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32820

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 W. T Biddle ST. 11-24 WARD)2. FULL NAME Rosie A. Quinn(a) RESIDENCE NO. 7 W Biddle St

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

singleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.66

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Baltimore  
Maryland10 NAME OF FATHER Wm P. Quinn11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Ireland12 MAIDEN NAME OF MOTHER Mary J. Smiley13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Albany  
New York

14

Informant  
(Address)Mrs. Marion A. Myers  
7 W. T Biddle St.

15 1928

C. HAMPTON JONES, M. D.  
RR 14  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 12, 1928, to April 13, 1928,that I last saw him alive on April 13, 1928,and that death occurred, on the date stated above, at 4:45 A. M.

The CAUSE OF DEATH\* was as follows:

acute cardiac failure  
arterio sclerosis, by pertension(duration) 24 yrs.

mos.

CONTRIBUTORY  
(Secondary)acute cardiac failure

(duration) yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?not knownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical methods(Signed) Frank R. Smith, Jr., M. D.19 (Address) 927 W. Calver St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cemetery4/14 1928

UNDERTAKER

ADDRESS

Henry W. Myers & Son805 W. Calver

32821

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32821

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 East 21st St.

ST. 12-50 WARD 90

2-FULL NAME Julia Ann Margaret Metcalfe

(a) RESIDENCE NO. 35 East 21st St.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 34 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

John Metcalfe

6 DATE OF BIRTH (month, day, and year) October 11, 1839

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

88

6

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Adams County  
(State or country) Pennsylvania

10 NAME OF FATHER Samuel Eppley

11 BIRTHPLACE OF FATHER (city or town) Adams Co.  
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Rebecca Bixler

13 BIRTHPLACE OF MOTHER (city or town) Manchester  
(State or country) Md.

14

Informant Miss Ida M. Metcalfe

(Address) 35 E. 21st St.

15

13 1928

G. HAMPTON JONES, M. D.

(Registrar)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 1923 to April 12, 1928.

that I last saw him alive on

April 12, 1928.

and that death occurred, on the date stated above, at 8.30 A. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) many yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

1928 (Address) 1003 Park Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

M. Olivet, Frederick

UNDERTAKER

Apr. 14 1928

ADDRESS

1003 West  
Baltimore



32822

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32822

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 Edmonson St., 16-22 WARD)

### 2-FULL NAME

William Blackford Osbourn

(a) RESIDENCE NO. 1904 Edmonson St.  
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 0 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Male white Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Osbourn

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years 79 Months 16 Days 5 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

File

3 1928

C. HAMPTON JONES, M. D., Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State) yrs. mos. ds.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 10, 1928, to Apr 12, 1928, that I last saw him live on Apr 12, 1928, and that death occurred, on the date stated above, at 8:30 P. M. The CAUSE OF DEATH\* was as follows:

Toxemia & Asthenia

CONTRIBUTORY (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

London Park Cemetery, 217 S. P.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32823

## CERTIFICATE OF DEATH.

66 E 32823  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. In rear of 600 W. Pratt St., 4-30 Ward)

2-FULL NAME Harry Penschmidt

(a) RESIDENCE NO. Unknown

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

Widower

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Lillie Penschmidt

8 DATE OF BIRTH (month, day, and year)

6/1/1866

7 AGE

Years

Months

Days

61

10

10

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Machinist(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto. Md.

10 NAME OF FATHER Henry Penschmidt

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Katherine Faubel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

Edward Breidenbaugh

(Address)

White Hall, Balto. Co.

15

Filed

C. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 11

1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry

and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Alcoholism

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

M. D.

4/13<sup>19</sup> 28. Address 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs. ....mos. ....ds.

In the

State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park Cemetery April 14, 1928

20 UNDERTAKER

ADDRESS

for President's Son 2178 Ave

E 32824

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

23 E 32824

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 409 S. Duncan

St. 2-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Ches

(a) RESIDENCE NO. 409 S. Duncan

(Usual place of abode)

St. Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 Filed

3 1928

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

April 13th, 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 7th, 1928, to April 13th, 1928,

that I last saw her alive on April 12th, 1928,

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

Encephalitis: (recurring after an original attack @ about 3 mos. of age.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Friedrich B. Hart

M. D.

(Address) 920 St Paul

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Rosary Cem April 14 1928

20 UNDERTAKER

ADDRESS

John M. Weber 401 S. Chester

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32825

## CERTIFICATE OF DEATH

46 E 32825

1-PLACE OF DEATH *2005 Pennrose Ave.*City of BALTIMORE: (No. *City of Baltimore* St. *20-27* Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Cora May Miller*(a) RESIDENCE NO. *2005 Pennrose Ave.* St. *20-27* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. *0* mos. *0* ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 Color or Race *white* 5 Single, Married, Widowed, or Divorced, (write the word) *widowed*5a If married, widowed, or divorced  
~~HUSBAND~~ of  
(or) WIFE of *Franklin P. Miller*6 DATE OF BIRTH (month, day, and year)  
*Oct. 7, 1858*7 AGE Years *69* Months *6* Days *5* IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *same duties*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *Md.*10 NAME OF FATHER *Ephraim Crum*11 BIRTHPLACE OF FATHER (City or town)  
(State or country) *Md.*12 MAIDEN NAME OF MOTHER *Susan R. Stone*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Md.*14 Informant *Mrs. Charles Hopkins*  
(Address) *2005 Pennrose Ave.*15 Filed *13 1928* *G. HAMPSON JONES* Registrar  
*RKA*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 12 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 10*, 19*25*, to *April 12*, 19*28*, that I last saw *her* alive on *April 12*, 19*28*, and that death occurred, on the date stated above, at *11.45 A.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of the uterus*(duration) *3* yrs. *0* mos. *0* ds.CONTRIBUTORY *none*  
(Secondary)(duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted

If not at place of death? *—*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical tests*  
(Signed) *Henry E. White*, M. D.*4-12, 1928* (Address) *1203 W. Fayette St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*London Park Cemetery**April 14, 1928*

20 UNDERTAKER

ADDRESS

*John O. Mitchell & Son* *1410 Eutan Pl.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32826

## CERTIFICATE OF DEATH

90 E 32826

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Hilton St. Towhatan Ave 45-67* Ward)2-FULL NAME *Mary Leith Rector*(a) RESIDENCE NO. *Hilton St. Towhatan Ave* St. WardLength of residence in city or town where death occurred *34* yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Howard N. Rector*6 DATE OF BIRTH (month, day, and year) *2-9-1844*7 AGE Years *84* Months *2* Days *3* IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*retired*9 BIRTHPLACE (city or town) (State or country) *Va.*10 NAME OF FATHER *Wm. G. Leith*11 BIRTHPLACE OF FATHER (City or town) (State or country) *Va.*12 MAIDEN NAME OF MOTHER *Frances Rhodes*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va.*14 Informant *Oliver L. Rector* (Address) *Hilton St. Towhatan Ave*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 12 1928*17 I HEREBY CERTIFY, That I attended deceased from *March 25, 1928*, to *April 12, 1928*.that I last saw him alive on *April 12, 1928*, and that death occurred, on the date stated above, at *7-45 a. m.*

The CAUSE OF DEATH\* was as follows:

*Influenza*CONTRIBUTORY (duration) yrs. mos. ds. *Chronic Myocarditis*(duration) yrs. mos. ds. *5 yrs.*18 Where was disease contracted *home* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical symptoms* (Signed) *Wm. Pearce* M. D., *St Paul Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

*Middlebury Va April 14 1928*  
*John O. Mitchell*

very important. See instructions on reverse side.

13 1528

C. HARRISON JONES, Jr.

RPH

Register

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32827

## CERTIFICATE OF DEATH

REGISTERED NO.

32827

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1000 Caton Ave* St. *12-49* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *2102 Nichols Ave* St. *Anne Arundel Co* Ward

(Usual place of abode)

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *25* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 Color or Race

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

*60* YearsMonths *11*Days *27*

IF LESS than 1 day...hrs. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

*unknown*

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

*Unknown*

## 10 NAME OF FATHER

*Unknown*

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*unknown*

## 12 MAIDEN NAME OF MOTHER

*unknown*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*unknown*

## 14

Informant (Address)

*Jenkins Memorial Hosp 1000 Caton Ave Baltimore*

## 15 Filed

13 1928

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*April 13 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*March 27, 1928, to April 13, 1928,*that I last saw him alive on *April 12, 1928,*and that death occurred, on the date stated above, at *12:30 A. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*

## CONTRIBUTORY

*Chronic Interstitial Nephritis*

(duration) ? mos. ds.

(duration) ? yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Francis L. DeDeagiacca, M. D.*

. 19

(Address)

*St Agnes' Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*St Marys Govenstown**4/14 1928*

## 20 UNDERTAKER

*Robert Brookeson*

ADDRESS

*Calhoun Hollins*

E 32828

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32828

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST. *9-17* WARD)2-FULL NAME *Mrs. Edith Serenella*  
(a) RESIDENCE NO. *87 Kinship's Reef* ST. WARD(Usual place of abode)  
Length of residence in city or town where death occurred — yrs. — mos. *5* ds. How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *F.* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced HUSBAND of (or) WIFE of *Joseph Serenella*DATE OF BIRTH (month, day, and year) *July 6 1894*  
AGE Years *43* Months *9* Days *7* If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Ohio*10 NAME OF FATHER *Albert Kuhn*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ohio*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Joseph Serenella*  
(Address) *87 Kinship's Reef*15 *131928* Filed *1928* Registrar *C. H. HARRISON*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/13/1928*17 I HEREBY CERTIFY, That I attended deceased from *4/8*, 19*28*, to *4/13*, 19*28*, that I last saw her alive on *4/13*, 19*28*, and that death occurred, on the date stated above, at *5:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Appendicitis**7* (duration) yrs. mos. *7* ds.CONTRIBUTORY (Secondary) *Embolism* (duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *7/10/28*Was there an autopsy? *No*What test confirmed diagnosis? *Examination of organs*  
(Signed) *J. H. HARRISON*, M. D.19 (Address) *St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Morgantown* DATE OF BURIAL *4/17 1928*20 UNDERTAKER *Robert Brookerson* Address *Baltimore*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32829

## CERTIFICATE OF DEATH.

49 32829  
REGISTERED NO. C

1-PLACE OF DEATH

Presby. F. E. &amp; T. Hosp.

CITY OF BALTIMORE: (No. 1017 E. Baltimore ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Raymond

(Residence in Baltimore: No. 117 N. Luzerne St., St.; 27 yrs., 7 mos. 16 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-~~STATUS~~MARRIED, ☒WIDOWED, ☐OR DIVORCED, ☐

(Write the word.)

6-DATE OF BIRTH,

August 28, 1898  
(Month) (Day) (Year)

7-AGE,

14  
27 yrs., 7 mos., 16 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife  
09-BIRTHPLACE,  
(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Walter Turner

11-BIRTHPLACE OF FATHER  
(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Maggie Woods

13-BIRTHPLACE OF MOTHER  
(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Turner

(Address) 1607 E. Baltimore

15-

Filed 191 C. HAMPTON JONES, M.D.

13 1928

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 12, 1928  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

4-10-1928, to 4-12-1928,

that I saw her alive on 4-12-1928, and that death occurred, on the date stated above, at 1:35 P.M.

The CAUSE OF DEATH\* was as follows:

Brain tumor

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY... Respiratory Failure...  
(Secondary)

(Duration) yrs. mos. 1/2 ds.

(Signed) B. S. Cameron, M. D.

191... (Address) 1017 E. Baltimore St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 117 N. Luzerne St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cemetery April 14, 1928

20-UNDERTAKER

ADDRESS

A. Howard Evans 356 E. Federal



32830

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101 E 32830

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 204 W 29th

## 2-FULL NAME

Sophie C Richter

(a) RESIDENCE NO.

204 W 29th

(Usual place of abode)

Length of residence in city or town where death occurred 1/0 yrs. mos. ds.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles M. Richter

DATE OF BIRTH (month, day, and year)

Feb 10, 1869

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

59

2

2

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Shanna T. Richter 204 W 29th St

15

Filed

19 HAMILTON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 12 1928

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1928, to April 12, 1928, that I last saw her alive on April 12, 1928, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia - Lobar

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4/13, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32831

## CERTIFICATE OF DEATH.

166E 32831  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospitals 6-9 Ward)2-FULL NAME Frances Stipek(a) RESIDENCE NO. 9 N. Chapel St

(Usual place of abode)

Length of residence in city or town where death occurred

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)

F

W

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofVincent Stipek

6 DATE OF BIRTH (month, day, and year)

1893

7 AGE

35 Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.34

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workAt home(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Bohemia

## 10 NAME OF FATHER

Thomas Doory

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Bohemia12 MAIDEN NAME OF MOTHER Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

B

PARENTS

very important.

13 1928

14

Informant Vincent Stipek(Address) 9 N. Chapel St

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 12/2817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-topsy or inquiry.) and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Carbolic Acid Poisoning-Suicide

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)(Signed) J. S. Batten

(Coroner)

(Address)

4/13/28500 E. North Ave\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ferts, or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Holy Redeemer4/14/28

## 20 UNDERTAKER

ADDRESS

William Cook502 E North

32832

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 Pinkney Place

ST. 12-19 WARD)

## 2-FULL NAME

Francis Oram Smith

(a) RESIDENCE NO. 420 Pinkney Place

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2+ yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11/1925

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

2

10

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Towson, Md.  
(State or country)

10 NAME OF FATHER Henry C. Smith

11 BIRTHPLACE OF FATHER (city or town) Harford Co., Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Mary ? Bottee

13 BIRTHPLACE OF MOTHER (city or town) Harford Co., Md.  
(State or country)14 Informant. Mother  
(Address)

15 1928 C. HAMPTON JONES, U. S. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13/28

17

I HEREBY CERTIFY, That I attended deceased from  
Apr 9/28, 19 to Apr 13/28, 19

that I last saw him alive on Apr 12/28, 19

and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH\* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY Diphtheria  
(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted At home  
if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Culture & Clinical  
(Signed) J. S. [Signature], M. D.

4/13/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

William Walters M.E.

4/14/28

20 UNDERTAKER

ADDRESS

William Cook Harford Co.

502 E North Ave

32833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 32833

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY ST. 19-27 WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Sullivan

(a) RESIDENCE NO. 412 W. St. Charles ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

7 DATE OF BIRTH (month, day, and year) \_\_\_\_\_

AGE Years 28 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Records

15 Filed 3 1928 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 18 19 28

17 I HEREBY CERTIFY, That I attended deceased from Apr. 28, 1928 to Apr. 3, 1928

that I last saw her alive on Apr. 3, 1928 and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH\* was as follows:

Interstitial nephritis - chronic & acute exacerbation

(duration) 1 yrs. 3 mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? General & Sub.

(Signed) C. J. Jones M. D. \_\_\_\_\_, 19 \_\_\_\_\_ (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. John's Church

4/14 1928

20 UNDERTAKER

ADDRESS

Thos. J. Sullivan

1318 Regent



E) 2987  
32834

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 32834

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

### 2. FULL NAME

Mabel Travers

### (a) RESIDENCE No.

709 H-Carey

(Usual place of abode)  
Length of residence in city or town where death occurred

25 yrs 1 mos 12 ds.

ST.

WARD

Now long in U. S., if of foreign birth?

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

Female

#### 4 COLOR OR RACE

Black

#### 5 Single, Married, Widowed, or Divorced, (write the word)

married

#### 6a If married, widowed, or divorced HUSBAND of (or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

3-1-03

#### 7 AGE

26 25

Months

1

Days

12

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 9 BIRTHPLACE (city or town) (State or country)

Ma -

### 10 NAME OF FATHER

Levers Church

### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

2a -

### 12 MAIDEN NAME OF MOTHER

Catherine

### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

2a -

### 14

Informant (Address)

### 15

4 Filed 1928

RECORDED & INDEXED  
JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

### 16 DATE OF DEATH (month, day, and year)

April 18 1928

### 17

I HEREBY CERTIFY, That I attended deceased from April 9, 1928, to April 18, 1928, that I last saw her alive on April 18, 1928, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH\* was as follows:

Endocarditis - mitral disease  
Thrombosis left femoral +  
right popliteal arteries

(duration) yrs. mos. 12 ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. 14 ds.

### 18 Where was disease contracted if not at place of death?

At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. H. Jones M. D.

4-13-28 Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE-

### DATE OF BURIAL

M. H. Hume

### 20 UNDERTAKER

Sam'l. H. Chase Son

Apr 15 1928

### ADDRESS

1400 M. cher

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E-32835 DEATH

166  
REGISTERED NO. 32835City of BALTIMORE: (No. *April Mercy A. Grant*)2-FULL NAME *Stephen R. James C. Dwyer*(a) RESIDENCE NO. *5-10 Eager*

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed  
or Divorced (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY

(Secondary)

(Signed)

(Coroner)

Address)

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

very important

4-15-28

C. HAMPSON JONES, M. D.  
R. R. R.Cathedral  
Bila Weddell 94 Greenet

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32836

## CERTIFICATE OF DEATH.

100-0191 32836

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *16 N. East Ave*ST. *6-11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Margaret Maxmion*(a) RESIDENCE NO. *16 N East Ave*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *2* mos. *7* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 6, 1928*

7 AGE

Years *2*

Months

Days *7*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*10 NAME OF FATHER *Mr Maxmion*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md*12 MAIDEN NAME OF MOTHER *Ellen McCormick*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md*

14

Informant (Address) *Father*

1928

G. HAMPSON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 13 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 10, 1928* to *April 13, 1928* that I last saw him alive on *April 13, 1928* and that death occurred, on the date stated above, at *1:45 A.M.*

The CAUSE OF DEATH\* was as follows:

*Bronchopneumonia*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. *2*

ds.

(duration)

yrs.

mos. *1*

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No*

Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Phys. data*(Signed) *Leo J. Hargis*

, 19

(Address) *303 4 E Balto St*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Cathedral*

DATE OF BURIAL

20 UNDERTAKER *Rita Wiedefeld*ADDRESS *914 Groomt Ave*

32837

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32837

18878 31

## CERTIFICATE OF DEATH.

31

18878 31

PLACE OF DEATH

CITY OF BALTIMORE: (No.)

Baltimore City Hospitals

23-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Leonard (Leonhart)

(a) RESIDENCE No. 1128 S. Charles st.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown

ST., WARD

(If non-resident give city or town and State) yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1887

AGE Years Months Days If LESS than 1 day. hrs. or min. 41

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Joseph Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 4 1928 G. HAMPSON JONES, Jr. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1928

I HEREBY CERTIFY, That I attended deceased from January 13, 1928, to April 12, 1928,

that I last saw him alive on April 12, 1928,

and that death occurred, on the date stated above, at 3:05 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis and enteritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) J. E. Madden, M. D.

(Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sacred Heart Cem.

Apr 16 1928

20 UNDERTAKER

ADDRESS

Lilly & Ziehl Inc.

1008 West 11



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32838  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

90 E 32838  
REGISTERED NO.City of BALTIMORE: (No. 3417 E. Lombard St. 26 Ward 27)2-FULL NAME Katherine Blauk

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3417 E. Lombard St. 26 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 40 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

George Blauk

6 DATE OF BIRTH (month, day, and year)

May 13<sup>th</sup> 1866

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

61

11

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)

Germany

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

PARENTS

14 Informant

(Address)

George Blauk, Husband  
3417 E. Lombard St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

April 12<sup>th</sup>

17

I HEREBY CERTIFY, That I attended deceased from

April 11, 1928, to April 12, 1928,

that I last saw her alive on April 10, 1928,

and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: Thy. G. Blauk, M. D.(Address) 143 N. 13th

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Sacred Heart Cemetery April 16<sup>th</sup> 1928

20 UNDERTAKER

Lilly &amp; Ziller Inc.

ADDRESS

463 S. Wolfe St

Filed

G. HAMPTON JONES, M. D.  
APR 11 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32839

## CERTIFICATE OF DEATH.

129 E 32839

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2804 Orleans St., 6-11 Ward)

## 2-FULL NAME

Anna Koenig

## (A) RESIDENCE NO.

2804 OrleansSt. 6 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

30 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Frank Koenig

## 6 DATE OF BIRTH (month, day, and year)

May 3<sup>rd</sup> 1858

## 7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

68119

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Germany

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

## 14

Informant

(Address)

Mr. Joseph Weigand  
2804 Orleans St.

## 15 Filed

4 1928

## 16

HAMPSON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

April 12<sup>th</sup>

## 17

I HEREBY CERTIFY, That I attended deceased from

April 7, 1928, to April 12, 1928;that I last saw her alive on April 12, 1928;and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia 2 days -  
arterio-sclerosis - chi. nephritis 8 yrs?

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

Emphysema -

(duration) 8 yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

## Did an operation precede death?

no

Date of

## Was there an autopsy?

no

## What test confirmed diagnosis?

My exam -

(Signed)

John F. Krumm, M. D.

, 19

(Address)

222 N. Kenwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery Apr. 17 1928

## 20 UNDERTAKER

ADDRESS

Lilly & Zeiler Inc. 4038 Wagon

32840

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2518 Oak St. ST. 12-51 WARD)

2-FULL NAME Margaret Woolford

(a) RESIDENCE No. 2518 Oak St. ST. 12-51 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) April 16-17  
AGE Years 11 Months 9 Days 16 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER James Woolford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna C. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14

Informant (Address) Anna C. Jones

15  
4 1928

C. HAMPSON JONES, M. D.  
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1928

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1928, to April 12, 1928, that I last saw her alive on April 12, 1928, and that death occurred, on the date stated above, at 12 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rickets and Malnutrition (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. F. Hall, M. D.

(Address) 426 E 23 St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. James

DATE OF BURIAL 4/12/28

20 UNDERTAKER Samuel H. Hensley

ADDRESS Md

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32841

## CERTIFICATE OF DEATH.

197 E 32841

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward 23531)2-FULL NAME Daniel Mullin.(C)(a) RESIDENCE NO. 141 W. West St.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married.5a If married, ~~XXXXXXXXXXXX~~  
HUSBAND of  
~~XXXXXXXXXX~~Rovina Mullin.(C)6 DATE OF BIRTH (month, day, and year)  
November 15, 19017 AGE Years Months Days IF LESS than  
26 4 24 13  
1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country).....

North Carolina.

10 NAME OF FATHER.....

Frank Mullin.(C)

11 BIRTHPLACE OF FATHER (city or town).....

(State or country).....

North Carolina.

12 MAIDEN NAME OF MOTHER.....

Sarah Thomas.(C)

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country).....

North Carolina.14 Informant Lena Anderson.(C) sister.(Address) 141 W. West St.

4 1928 G. HAMPSHIRE JONES, JR. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said autopsy and inquest and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Internal Hemorrhage.  
Pistol shot wound in the Pelvis.  
Homicide.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary).....

(duration) .....yrs. ....mos. ....ds.  
(Signed) [Signature] M. D.  
(Coroner)4/15, 1928 (Address) 1017 E. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

900 block Peach St. Apr. 8, 1928

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

W. Calvert July 14 1928  
R. L. Parker 829 Beaman St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32842

E 32842

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1253 Light ST., 23-33 WARD)2—FULL NAME Mary D. Hill(a) RESIDENCE NO. 1253 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town). (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town). (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town). (State or country)

Informant

(Address)

4 1928

HARRISON JONES 12. 2.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1928, to April 13, 1928,

that I last saw her alive on April 13, 1928, and that death occurred, on the date stated above, at about 9 P. M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? 228 Date of

Was there an autopsy? 228

What test confirmed diagnosis?

(Signed)

M. D.

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 32843

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

X 118-001  
E 32843

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mersey Hospital St., 4-7 Ward)2-FULL NAME Walter Conaway(a) RESIDENCE NO. Wheeling, W. Va

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

male

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

5-7

IF LESS than  
1 day hrs.  
or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Broker

9 BIRTHPLACE (city or town)  
(State or country)

Unknown

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14 Informant  
(Address)

J. H. Jones

15 Filed

C. H. JONES, M. D.

Registrar

14 1928

REGISTERED NO.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

4/13/28

17

I HEREBY CERTIFY, That I attended deceased from

3/18/28, 19 to 4/13/28, 19

that I last saw him alive on 4/13/28, 19

and that death occurred, on the date stated above, at 10:05 pm

The CAUSE OF DEATH\* was as follows:

Pulmonary Embolism

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos. 14

da.

(duration)

yrs.

mos.

da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of 3/19/28

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed)

, 19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Baltimore, Md

4/14/28

J. H. Jones

E 32844

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

46 E 32844

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malinda Washington(a) RESIDENCE NO. 649 W. Lafayette St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 48 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer-United Pwy  
(b) General nature of industry, business, or establishment in which employed (or employer) 040  
(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland10 NAME OF FATHER Samuel Syle11 BIRTHPLACE OF FATHER (City or town) (State or country) Va.12 MAIDEN NAME OF MOTHER Ann Lewis13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.14 Informant David Washington  
(Address) 649 Lafayette Ave

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/2817 I HEREBY CERTIFY, That I attended deceased from 11/10/27, 19\_\_\_\_, to 4/12/28, 19\_\_\_\_, that I last saw her alive on 4/12/28, 19\_\_\_\_, and that death occurred, on the date stated above, at 5:55 m.

The CAUSE OF DEATH\* was as follows:

Abdominal Carcinoma-  
Taxis-Primary in right  
Ovary  
(duration) \_\_\_\_\_ yrs. 18 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_\_ yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of 11/21/28

Was there an autopsy?

What test confirmed diagnosis? operation(Signed) J. S. Winkler, M. D.  
. 19 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Int. Auburn Cemetery  
Thomas C. KellanApril 16 1928  
1303  
Eastman St

APR 14 1928

G. HAMPTON JONES, M.  
Registrar

very important. See instructions on reverse side.

E 32845 HEALTH DEPARTMENT—CITY OF BALTIMORE E 32845

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. *2545 N. Fairmount St.* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Mrs. Margaret Schmelz,*(a) RESIDENCE NO. *2545 N. Fairmount St.* WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced

~~HUSBAND~~ (or) WIFE of *Frank Schmelz*6 DATE OF BIRTH (month, day, and year) *Dec. 27, 1864*7 AGE Years *63* Months *7* Days *16* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Christian Byers*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14

Informant *Otha Kilgortner* (Address) *4825 Homer Lane*

APR 14 1928

C. HAMPSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 13, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Sept 8, 1923* to *April 13, 1928*, that I last saw him alive on *March 31, 1928*, and that death occurred, on the date stated above, at *4 a. m.*

The CAUSE OF DEATH\* was as follows:

*Angina Pectoris*(duration) *4* yrs. *7* mos. *5* ds.CONTRIBUTORY *Atherosclerosis* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *At Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical examination* (Signed) *Charles Esch*, M. D.*Apr. 13, 1928* (Address) *1111 N. Laurens St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *London Park*DATE OF BURIAL *April 16, 1928*20 UNDERTAKER *George Smith*ADDRESS *1532 Hollins*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32846

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1239 Riverside Ave. 24-33)

## 2-FULL NAME

Thomas C. Gory

(a) RESIDENCE NO.

1239 Riverside Ave.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar. 20<sup>th</sup> 1893

7 AGE

Years

Months

Days

35

22

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Sheet Cutter

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

City

10 NAME OF FATHER

Wm. C. Gory

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

City

12 MAIDEN NAME OF MOTHER

Carrie A. Smith

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

City

14

Informant  
(Address)Edw. Gory  
1239 Riverside Ave.

15

Filed

G. H. JONES, Jr.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 12<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 15, 1928, to April 12, 1928.

that I last saw him alive on

April 11, 1928

and that death occurred, on the date stated above, at

4 A m.

The CAUSE OF DEATH\* was as follows:

Pulmonary  
Tuberculosis  
DefunctCONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

R. H. Campbell, M. D.

4/13, 1928 (Address)

1644 Haverhill St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Baltimore Cemetery

4/14/1928

20 UNDERTAKER

ADDRESS

E. O. Fanning, Jr. - 1468 Battery Ave.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

32847

## CERTIFICATE OF DEATH.

38E 32847

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 76-37 WARD)

2. FULL NAME Otto Stanson

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. BALTIMORE CITY HOSPITALS ST. 76-37 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 7 yrs. 0 mos. 0 ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widowed

If married, widowed, or divorced HUSBAND of or WIFE of ?

DATE OF BIRTH (month, day, and year) ?

AGE Years 48 Months 0 Days 0 If LESS than 1 day, 0 hrs. 0 min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 30

(c) Name of employer 0

9 BIRTHPLACE (city or town) Germany  
(State or country)

10 NAME OF FATHER Max Stanson

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Delany Bugh

13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)

14 Informant Records  
(Address)

15 Filed 14 1928 19 C. HAMPSHIRE  
2360

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/1928

17 I HEREBY CERTIFY, That I attended deceased from Mar 11, 1928 to Apr 10, 1928 that I last saw him live on Apr 10, 1928 and that death occurred, on the date stated above, at 4:10 A. m.

The CAUSE OF DEATH\* was as follows:

Acute myocardial infarction  
myocarditis - chronic & acute  
Cholera - suppurative

(duration) yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) (duration) yrs. 0 mos. 0 ds.

18 Where was disease contracted ?  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Sub  
(Signed) C. D. Holmes M. D.  
19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

20 UNDERTAKER

B. COMMISSIONER HEALTH

APR 14 1928

## HEALTH DEPARTMENT-CITY OF BALTIMORE

E 32848

## CERTIFICATE OF DEATH.

REGISTERED NO. 32848

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1030 E. Monument St. 10-14 Ward)

## 2-FULL NAME

Ruth Johnson

## (a) RESIDENCE NO.

1030 E. Monument St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F.

## 4 Color or Race

C.

## 5 Single, Married, Widowed, or Divorced, (write the word)

S

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Apr 9/28

## 7 AGE

Years

Months

Dnys

3

IF LESS than  
1 day.....hrs.  
or.....min.

2 1/2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

none

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore

## 10 NAME OF FATHER

Lester Chase

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

310 N. E. Monument St.

## 12 MAIDEN NAME OF MOTHER

Evelyn Johnson

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

1030 E. Monument St.

## 14

Informant  
(Address)

Mother

15 1928 C. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr 10/28

## 17

I HEREBY CERTIFY, That I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said  
Inquest, au-  
topsy or inquiry, and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Infection Remittent

7 months gestation

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

J. H. Jones

(Coroner)

1928 (Address)

1030 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

Very Important - See Back

UNIVERSITY OF MARYLAND

19

APR 14 1928

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32849

## CERTIFICATE OF DEATH.

161-001 E 32849

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Don Secours* ST. *1400* WARD *1*)

### 2-FULL NAME

(a) RESIDENCE NO. *1400* ST. *1* WARD *1*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *M*

5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *Apr 12 1928*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md*

10 NAME OF FATHER *Harold H. Kasser*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*

12 MAIDEN NAME OF MOTHER *Mrs. Mary J. Kasser*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14 Informant (Address) *1400 Secours*

15 Filed *14 1928*

*MATTHEW JONES* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 14 - 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Apr 12 - 1928*, to *Apr 14 - 1928*, that I last saw him alive on *Apr 14 - 1928*, and that death occurred, on the date stated above, at *3:15 A. m.*

The CAUSE OF DEATH\* was as follows:

*Prematurity (weight = 3'13")*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

*Congenital atelectasis*

18 Where was disease contracted if not at place of death? *✓*

(duration) yrs. mos. ds.

Did an operation precede death? *No* Date of *✓*

Was there an autopsy? *No*

What test confirmed diagnosis? *✓*

(Signed) *Budley P. Bame*, M. D.

*4-14, 1928 (Address) 1904 N. Charles St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Holy Cross Con*  
*For & Family Funeral Society*



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32850

## CERTIFICATE OF DEATH.

E 32850

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 914 N. Gay St

10-14 Ward

## 2-FULL NAME

Nellie V. Jones

## (a) RESIDENCE NO.

914 N. Gay St

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

widow

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John G. Jones

## 6 DATE OF BIRTH (month, day, and year)

Apr 20/1881

## 7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

46

11

24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town).....

(State or country)

Norfolk Va

## 10 NAME OF FATHER

Geo. G. Buford

## 11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Gales Co., N.C.

## 12 MAIDEN NAME OF MOTHER Georgia E. Jones

## 13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Gales Co., N.C.

## 14

Informant Sam'l N. Jones (Son)  
(Address) 914 N. Gay St

## 15

1928

1911

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 13/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular Cardiac Insufficiency  
(History of Rheumatism)

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed)

(Coroner) M. D.

4/14/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32851

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO. C

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

APR 15 1928

HARRISON JONES, M.  
RegistrarGreenmount & Glen  
Henry Jenkins & Son Co  
4100 N. Charles St.

E 32852

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32852

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *418 Washington St.*)

## 2-FULL NAME

*Charles E. Chenoweth*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

(Usual place of abode)

*Lock Raven Md.*

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

*9*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male White Widowed*

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Widower*

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*57**7**28**Aug 17-1871*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

*C. L. Clemens*

(c) Name of employer

## 9 BIRTHPLACE (city or town); (State or country)

*Maryland*

## 10 NAME OF FATHER

*unknown*

## 11 BIRTHPLACE OF FATHER (city or town); (State or country)

*Maryland*

## 12 MAIDEN NAME OF MOTHER

*unknown*

## 13 BIRTHPLACE OF MOTHER (city or town); (State or country)

*Germany*

## 14

Informant (Address)

*Samuel P. Chenoweth  
Lock Raven Md.*

APR 15 1928 C. HAMPTON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-14-1928*

17

I HEREBY CERTIFY, That I attended deceased from

*4-5-28*, 19, to *4-14-28*, 19that I last saw him alive on *4-14-28*, 19and that death occurred, on the date stated above, at *9:00 P.* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of  
stomach*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *John Burns*, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

## DATE OF BURIAL

*Chenoweth family cemetery  
Lock Raven Md.**April 17 1928*

## FUNERAL

## ADDRESS

*John Burns Sons**Towson Md*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32853

## CERTIFICATE OF DEATH.

90E 32853

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1103 Valley*)

ST. *10-14* WARD)

### 2. FULL NAME

*Robert J. Lucky*

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### (a) RESIDENCE NO.

*1103 Valley*

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred *40* yrs. mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*

DATE OF BIRTH (month, day, and year) *May 3, 1870*

AGE Years Months Days If LESS than 1 day, hrs. or min. *57 11 10*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired Labor*

(b) General nature of industry, business, or establishment in which employed (or employer) *Water Dept.*

(c) Name of employer *City.*

BIRTHPLACE (city or town) (State or country) *New York*

10 NAME OF FATHER *Wm. Lucky*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*

12 MAIDEN NAME OF MOTHER *Ann McCalligan*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Irish*

14 Informant *Mrs. Cairns* (Address) *1103 Valley St.*

APR 15 1928 C. HANSON JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 13, 1928*

17 I HEREBY CERTIFY, That I attended deceased from *April 12, 1928* to *April 13, 1928*, that I last saw him alive on *April 12, 1928*, and that death occurred, on the date stated above, at *a* m. The CAUSE OF DEATH\* was as follows:

*Chronic Endocarditis*

*Unknown* (duration) yrs. mos. ds.

CONTRIBUTORY *Ordinary* (Secondary) (duration) *1* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *H. B. Jones* M. D.

Address *914 E. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Holy Cross Cemetery* DATE OF BURIAL *April 1928*

UNDERTAKER ADDRESS

*Edmund W. Bonklein 924 E. Bay St.*



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32854  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 32854

CITY OF BALTIMORE: (No. 2810 Rayner Ave. 16-68 ST. 16 WARD)

2-FULL NAME William Arnold Dorsey

(a) RESIDENCE NO. 2810 Rayner Ave.  
(Usual place of abode)

Length of residence in city or town where death occurred Life mos.

REGISTERED NO. 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD 16

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) June 23-1926

AGE

Years 1

Months 9

Days 21

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Wm E Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen M. Watters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14

Informant (Address) Wm E Dorsey  
2810 Rayner Ave

15

R 15 1928

C. HAMPSHIRE JONES, M. D.  
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14-1928

17

I HEREBY CERTIFY, That I attended deceased from 3/20, 1928, to 4/14, 1928

that I last saw him alive on 4/14, 1928 and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH\* was as follows:

Measles

CONTRIBUTORY (Secondary) Pneumonia

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X-ray

(Signed) Charles R. Jones M.D.  
Address Medical Art Bldg.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Brooklyn Cemetery

DATE OF BURIAL Apr 16-1928

UNDERTAKER W. H. Ham

ADDRESS 1723 N. L...

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32855

E 32855

**CERTIFICATE OF DEATH.**

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5904 Highgate Drive St. 7-5 WARD 1)

2-FULL NAME Barney Pickins

(a) RESIDENCE NO. 5904 Highgate Drive  
(Usual place of abode) ST. WARD  
Length of residence in city or town where born 25

Length of residence in city or town where death occurred 35 yrs. 12 mos.

ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

REGISTERED NO. ....  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) *11/11/1961*

AGE	Years	Months	Days	If LESS than 1 day..... hrs or..... min.
	64	—	—	

**OCCUPATION OF DECEASED**

(a) Trade, profession or particular kind of work..... Housework

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) **Name of employer**

9 BIRTHPLACE (city or town) ...  
(State or country) *Russia*

10 NAME OF FATHER *Elyah Ziskind*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER *Rea Frank*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14 Informant Moses R. W. Kind  
(Address) 2901

15  
PP 15 1928

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) *April 14 1928*

17 I HEREBY CERTIFY, That I attended deceased from  
May, 1927, to April 17, 1928.  
that I last saw him alive on April 13, 1928.  
and that death occurred, on the date stated above, at 3 P. M.  
The CAUSE OF DEATH\* was as follows:

Corrin was 74 years old.

(duration) 2 yrs.    mon    da

**CONTRIBUTORY**  
(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

### Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel H. Love, M. D.

19 (Address) 1815 E. 1st Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKES

ADDRESS 1127

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32856

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 6 West Belts General St. 100-001

## 2-FULL NAME

Otto Miller

## (a) RESIDENCE NO.

(Usual place of abode)

3rd &amp; Audrey Ave. 3rd

## WARD

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

40 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Augusta Miller

DATE OF BIRTH (month, day, and year)

Mar 23-1864

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

64

1

21

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Roadwork

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Albert Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Marie Schuman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs Augusta Miller 3rd &amp; Audrey Ave

APR 15 1928

HAYSON JONES, M.D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 13 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 7, 1928, to April 13, 1928.

that I last saw him live on April 13, 1928.

and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH\* was as follows

Broncho Pneumonia

(duration) yrs. mos. 13 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

Clin. Exam.

4/13/28 (Signed)

Louis T. Levy, M.D.

W. Balto Gen Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cem

DATE OF BURIAL

April 16 1928

20 UNDERTAKER

J. J. Jones

ADDRESS

T-La

32857

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32857

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

## 2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode.)

Length of residence in city or town where death occurred

43 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

a If married, widowed, or divorced HUSBAND or or WIFE of

Mary Kathleen Heilach

DATE OF BIRTH (month, day, and year)

Dec 2, 1862

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

4

11

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter &amp; Decorator

(b) General nature of industry, business, or establishment in which employed (or employer)

Beckley

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Francis T. Heilach

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Heilach

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mr. J. Milton Brandt 308 Bittings Ave

15

APR 15 1928

C. HADSON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 13 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar 31, 1928 to Apr 13, 1928.

that I last saw him live on Apr 12, 1928

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH\* was as follows:

Hemorrhage in stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Coronary Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Chas. Jones M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cmg

Apr 16, 28

20 UNDERTAKER

ADDRESS

Wm. J. Hickner 100 North La



E 32858

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Motherhouse of Notre Dame* ST. *10-14* WARD)

2-FULL NAME *Mary Gertrude Rath*

(a) RESIDENCE NO. *Disquette St*  
(Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. *50* mos. *50* ds. How long in U. S., if of foreign birth? *50* yrs. *50* mos. *50* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb - 24 - 1859*

7 AGE *69* Years *1* Months *21* Days *20* hrs *20* min. If LESS than 1 day, hrs or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Home Duties*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany*  
(State or country)

10 NAME OF FATHER *John Rath*

11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)

12 MAIDEN NAME OF MOTHER *Elise Pfefferman*

13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)

14 Informant *Sister Mary Winifred, Notre Dame*  
(Address) *Disquette St City*

15 *APR 15 1928* C. HAMPTON JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April - 14 - 1928*

17 I HEREBY CERTIFY, That I attended deceased from *March - 18 - 1925* to *April - 14 - 1928*, that I last saw her alive on *April - 13 - 1928*, and that death occurred, on the date stated above, at *4 - a. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*  
*Chronic Myocarditis*  
(duration) yrs. mos. *29* ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *usual ones*  
(Signed) *F. J. Purdy* M. D.

*4/14/1928* (Address) *110 E North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*North Cliff Md.*  
U. S. DEPT. OF HEALTH  
Frank A. Fink

*April 16 1928*  
ADDRESS  
*915 N. Gay*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32859

## CERTIFICATE OF DEATH.

E 32859

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3717 Towanda ave ST. 50 WARD)

## 2. FULL NAME

Coleman Harris

## (a) RESIDENCE NO.

3717 Towanda ave ST. 50 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

50 yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

a If married, widowed, or divorced HUSBAND of or WIFE of

Adeline Harris

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

65

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Harry Harris

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Sol Widorowicz 3717 Towanda ave

15

APR 15 1928

C. HAMPTON JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/13 1928

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to April 13, 1928,

that I last saw him alive on

April 13, 1928

and that death occurred, on the date stated above, at

1215 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical

(Signed)

H. H. Jones (Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Hebrew Burial Society 4/15 1928

Jack Lewis 1439 E. Baltimore Ave

E 32860

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 E 32860

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore Hospital 8-17* ST. *8-17* WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *May Feldman*

(a) RESIDENCE NO. *1618 E Preston* ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred *18* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? *18* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

a If married, widowed, or divorced HUSBAND of (or) WIFE of *Elta Feldman*

DATE OF BIRTH (month, day, and year) *unknown*

AGE *54* Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *press*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Russia*  
(State or country)

10 NAME OF FATHER *Louis Feldman*

11 BIRTHPLACE OF FATHER (city or town) *Russia*  
(State or country)

12 MAIDEN NAME OF MOTHER *Sara Ungochman*

13 BIRTHPLACE OF MOTHER (city or town) *Russia*  
(State or country)

14 Informant *Elta Feldman*  
(Address) *1615 E Preston St*

15 *C. HAYSON JONES, M. D.*  
PR 15 1928 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 14 1928*

17 I HEREBY CERTIFY, That I attended deceased from *4-3-1928* to *4-14-1928* that I last saw *him* alive on *4-14-1928* and that death occurred, on the date stated above, at *12:30* m.

The CAUSE OF DEATH\* was as follows:  
*Coronary Thrombosis*

### CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *no*

What test confirmed diagnosis? *Physical Signs*  
(Signed) *B. J. ... M. D.*

(Address) *Baltimore City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Hebrew Cemetery*

UNDERTAKER *Jack Lewis 1439*

### DATE OF BURIAL

*4/15 1928*

ADDRESS *1615 E Preston St*

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 32861

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *2102 E. Baltimore St*  
CITY OF BALTIMORE (No. *Insurable Home*)

2-FULL NAME *Genandell Cohen*

(a) RESIDENCE NO. *2212 Eutaw Place* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *15* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*F*

*white*

*widow*

If married, widowed, or divorced HUSBAND of or WIFE of

*Samuel Cohen*

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*88*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*old aged*

(b) General nature of industry, business, or establishment in which employed (or employer)

*none*

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Russia*

10 NAME OF FATHER

*Isaac L. Liviner*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Goldie F. Forman*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Russia*

14 Informant

(Address)

*J. Brampton 2215 Eutaw Place*

15

APR 15 1928 HANCOCK JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4/14 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Oct* 19 *7* to *4-14, 1928*

that I last saw him alive on *4-14, 1928*

and that death occurred, on the date stated above, at *9 a* m.

The CAUSE OF DEATH\* was as follows:

*arterio-sclerosis*

(duration) *15* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Samuel L. Liviner* M. D.

19 (Address) *1800 Eutaw Pl.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

*Rehrein Road*

20 UNDERTAKER

*John Lewis 1439 E. Pratt St*

DATE OF BURIAL

*4/15 1928*

ADDRESS



E 32862 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 32862

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Simia Hospital* ST. *15-21* WARD)

2-FULL NAME *Sophia Veir*

(a) RESIDENCE NO. *2000 Walkbrook Ave* ST. *6* WARD

(Usual place of abode)  
Length of residence in city or town where death occurred *6* yrs. mos. ds. How long in U. S., if of foreign birth? *6* yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *F* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *mar*

If married, widowed, or divorced  
HUSBAND of *Abraham Veir*  
or WIFE of

DATE OF BIRTH (month, day, and year) *unknown*

AGE Years *68* Months *—* Days *—* If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Russia*

10 NAME OF FATHER *Isaac*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*

12 MAIDEN NAME OF MOTHER *Isaac*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14 Informant *Samuel Shochet*  
(Address) *2218 St. Monroe St*

15 R 15 1928 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/14* 19 *28*

17 I HEREBY CERTIFY, That I attended deceased from *Jan*, 19 *28*, to *Jul 14*, 19 *28*, that I last saw him alive on *April 14*, 19 *28*, and that death occurred, on the date stated above, at *3 P* m.  
The CAUSE OF DEATH\* was as follows:

*coronary artery of infarction*  
(duration) yrs. *4* mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Levitt*, M. D.  
, 19 (Address) *1810 E. 1st St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Westmen Acre Cem*

DATE OF BURIAL *4/15* 19 *28*

20 UNDERTAKER *Jack Lewis 1439 E. 1st St*

32863

# HEALTH DEPARTMENT—CITY OF BALTIMORE.

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

*Sinai Hospital*

CITY OF BALTIMORE: (No.

ST. *6-10* WARD)

2-FULL NAME

*George Kopp*

(a) RESIDENCE NO.

*126 N. Patterson Park Ave*

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*life*

ys.

mos.

ds. How long in U. S., if of foreign birth?

ys.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

*Bertie Kopp*

7 DATE OF BIRTH (month, day, and year)

*Feb 20/1870*

AGE

Years

Months

Days

If LESS than 1 day, hrs or min

*58*

*1*

*23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Moulder*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Isaac Sheppard*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*George Kopp*

11 BIRTHPLACE OF FATHER (city or town)

*Germany*

12 MAIDEN NAME OF MOTHER

*Agatha Houck*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Bertie Kopp 126 N. Patterson Park Ave*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 13 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*4-13 1928* to *4-13 1928*

that I last saw him alive on

*4-13 1928*

and that death occurred, on the date stated above, at

*11 P M*

The CAUSE OF DEATH<sup>a</sup> was as follows:

*Terminal bilateral broncho pneumonia  
Ruptured appendix - Peritonitis*

CONTRIBUTORY (Secondary)

*Cancer of liver*

18 Where was disease contracted if not at place of death?

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*Yes*

What test confirmed diagnosis?

(Signed)

*Dr. Schwedel*

M. D.

Address

*Sinai Hospital*

<sup>a</sup>State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Germ. Univ. Cemetery*

*4/16 1928*

20 UNDERTAKER

ADDRESS

*Walter Davis 3307 Paine St*

PR 15 1928

C. H. JONES

HEALTH DEPARTMENT—CITY OF BALTIMORE

32864

CERTIFICATE OF DEATH

129E 32864

1-PLACE OF DEATH

City of BALTIMORE: (No. 1610 Rutland St. 8-17 Ward)

2-FULL NAME Louisa Wright

(a) RESIDENCE NO. 1610 Rutland St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. — mos. — da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? — yrs. — mos. — da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Edward A. Wright. (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE Years 62 Months — Days — IF LESS than 1 day — hrs. or — min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Balls Blad. (State or country)

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (City or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Quirkell

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant M. Edwards G. Wright (Address) 1610 Rutland St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 19 28

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1926, to Apr. 13, 1928, that I last saw her alive on April 9, 1928, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis.

CONTRIBUTORY (Secondary)

(duration) 1 1/2 yrs. — mos. — da.

(duration) — yrs. — mos. — da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Talbot, M. D.

(Address) 701 N. Kenwood St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Baltimore Cemetery

Apr. 16 1928

UNDERTAKER

ADDRESS

Henry Hooker

1301 E. Eager

APR 15 1928 C. HAMPSOR JONES, M. Registrar

very important. See instructions on back of card.

E 32865

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32865

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Muldown(a) RESIDENCE NO. 1033 Stonewood Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

a If married, widowed, or divorced

HUSBAND of  
or WIFE ofBelia Muldown

DATE OF BIRTH (month, day, and year) ?

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.55

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md.

10 NAME OF FATHER

Michael Muldown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant  
(Address)Reverend

15

PR 15 1928

G. HANSON JONES  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 7, 1928, to Apr. 13, 1928that I last saw him on Apr. 13, 1928and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH\* was as follows:

hepatitis - chronic -  
arteriosclerotic - necrosis(duration) yrs. 2 mos. ds.CONTRIBUTORY  
(Secondary)Myocarditis, chronic

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

General + Sub.

(Signed)

C. J. Jones, M.D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAT  
New Cathedral CemeteryApr. 17, 1928

20 UNDERTAKER

ADDRESS

Harry Hochman1301 E. Eager St.



E 32866

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1509 Vine* ST. *19-27* WARD)2. FULL NAME *James Kennard*(a) RESIDENCE NO. *1509 Vine*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred *29* yrs. *11* mos. *10* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male* *Red**Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 2 1898*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*29* *11* *10*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Helper in Market*

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

C. HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 12 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr 3rd 1928* to *Apr 12 1928*that I last saw him alive on *Apr 12 1928*and that death occurred, on the date stated above, at *3 P.M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

(Address)

*Regular*  
*J. B. Link* M. D.  
*with Dr. Downin*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Auburn Cem* *Apr 16th 1928*

UNDERTAKER

ADDRESS

*C. Jones**11 S. Gilmor St*

APR 15 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32867

## CERTIFICATE OF DEATH

REGISTERED NO.

32867

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2000 *E. Lamale* St. *8-17* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Matalda C. Walther*(a) RESIDENCE NO. *2000 E. Lamale* St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *70* yrs. mos. ds. How long in U. S. if of foreign birth? *70* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

16 DATE OF DEATH (month, day, and year)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

17

I HEREBY CERTIFY, That I attended deceased from

March 19, 1928, to April 12, 1928

that I last saw him alive on April 12, 1928

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

April 10, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

APR 15 1928

G. HAMPSON JONES, M.D.

Western

Mendell Dippel &amp; son 37 Sam

E 32868

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32868

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

### 2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

a If married, widowed, or divorced

HUSBAND of (or) WIFE of

James T. Ripley

DATE OF BIRTH

Unknown

1856

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

72

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Maryland

10 NAME OF FATHER

Nicholas Toomey

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

Mr. Harry E. Ripley

(Address)

1174 Washington Blvd.

15

File

APR 15 1928

C. H. JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14/28 19

17

I HEREBY CERTIFY, That I attended deceased from

4/9, 1928, to 4/14, 1928,

that I last saw her live on 4/13, 1928

and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH\* was as follows:

Myocarditis  
Pneumonia

Unknown (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac Dehydration

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clarence A. Lawrence, M. D.

4/14/28 (Address)

St. Joseph Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Loudon Park Cemetery

DATE OF BURIAL

April 16 1928

UNDERTAKER

ADDRESS

1003 W.

Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

C.

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

If married, widowed, or divorced

HUSBAND of  
or) WIFE of

Hester Washington

DATE OF BIRTH (month, day, and year)

Unknown 1864

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

64

## OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Prince George's  
Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant  
(Address)Mary Edwards  
1212 N. Wolfe St.

15

5 1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 12 - 19 28

17

I HEREBY CERTIFY, That I attended deceased from

Apr 9, 19 28, to Apr 11, 19 28,

that I last saw him alive on Apr 11, 19 28,

and that death occurred, on the date stated above, at 3 9, m.

The CAUSE OF DEATH\* was as follows:

Acute Broncho Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

Physical

(Signed) A. H. Hornstein, M. D.

4/14, 19 28 (Address) 733 Aspinwall St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Ashbury Cemetery

Apr. 13, 19 28

UNDERTAKER

ADDRESS

Thos. R. A. Elliott

1125  
Ashbury Lane



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32870

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 E Madison

ST. 10-13 (WARD)

## 2-FULL NAME

Solomon Barnett

(a) RESIDENCE NO. 1432 E. Madison

(Usual place of abode)

Length of residence in city or town where death occurred 45

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

Married.

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Florence Barnett

6 DATE OF BIRTH (month, day, and year)

Feb 29, 1878

7 AGE

Years

Months

Days

50

1

23

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Southern Railway Co. Md.

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Samuel Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant

(Address)

Florence Barnett

1432 E. Madison St.

Filed

15 1928 G. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 12 1928

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1928, to April 12, 1928.

that I last saw him alive on April 12, 1928.

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage with facial Paralysis and Hemiplegia (2 attacks) (duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no

Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical

(Signed)

4/13/28

(Address)

1432 E. Madison St.

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Ashbury Cemetery

April 15, 1928

UNDERTAKEN

Mrs. R. G. Elliott

ADDRESS

1725

Ashbury

E 32871

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3415 Holmes Ave.

ST., 13-59 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Jacobs

(a) RESIDENCE No. 3415 Holmes Ave.  
(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

Anna Jacobs

DATE OF BIRTH (month, day, and year) About 1844.

AGE 84 Years Months Days If LESS than 1 day, hrs. or min. About 83.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired General

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant.

(c) Name of employer

BIRTHPLACE (city or town) Poland.  
(State or country)

10 NAME OF FATHER Jacob Jacobs

11 BIRTHPLACE OF FATHER (city or town) Poland  
(State or country)

12 MAIDEN NAME OF MOTHER Rose Levin

13 BIRTHPLACE OF MOTHER (city or town) Poland.  
(State or country)14 Informant Mrs. Anna Jacobs  
(Address) 3415 Holmes Ave

15 Filed 1928 C. HAMMOND JONES, R. M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14th. 1928

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1928, to April 14, 1928, that I last saw him alive on April 14, 1928, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Angina Pectoris  
(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel W. Valen, M. D.

, 19 (Address) 2444 Eutaw Place.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hebrew Friendship Cem.

4/15/ 1928

20 UNDERTAKER

ADDRESS 118-20 W. Mt. Royal Ave.

Registrar

## E 32872 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32872

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 S Badford ST. 1-3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Anthony Cebulski

(a) RESIDENCE NO. 615 S Bradford

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 3 1926

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

1

9

11

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore Md.

10 NAME OF FATHER Anthony Cebulski

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER Frances Kriegler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

14

Informant Frances Cebulski

(Address)

615

S

Bradford

St.

PR 15 1928 C. HAMMOND JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 19 28

17

I HEREBY CERTIFY, That I attended deceased from April 12, 19 28, to April 14, 19 28, that I last saw him alive on April 14, 19 28, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Andrew Kunkowski, M. D.

4/14, 19 28 (Address) 2579 Easton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Rosary April 16 19 28  
John M. Weber 4012 Chester St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32873

## CERTIFICATE OF DEATH.

E 32873

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 174 N. Milton Ave ST. 10 WARD)

### 2-FULL NAME

Clivia Gardner

### (a) RESIDENCE NO.

174 N. Milton Ave

(Usual place of abode)

### WARD

Length of residence in city or town where death occurred 87 yrs. mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White 5 Single, Married, Widowed, Widow  
(If married, widowed, or divorced, write the word)

If married, widowed, or divorced

HUSBAND of (or) WIFE of

George Gardner

DATE OF BIRTH (month, day, and year)

2/2/1881

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

2

1

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

George Bied

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Christina Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

Mary C. Jones  
174 N. Milton Ave

15

15 1928

C. HAMPTON JONES, M. D.  
Registral

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/13/1928

17

I HEREBY CERTIFY, That I attended deceased from Feb, 1928, to April 11th, 1928.

that I last saw her alive on April 11th, 1928, and that death occurred, on the date stated above, at 6:21 P. M.

The CAUSE OF DEATH was as follows:

Arterio Sclerosis  
8. nephros

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

H. J. Janter

M. D.

(Address)

119 N. Milton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MUTAL

Baltimore Ceme

DATE OF BURIAL

Apr 14, 28

20 UNDERTAKER

John Ullrich

ADDRESS

2000



E 32874

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *300 N-Mount* ST. *14-27* WARD)

### 2-FULL NAME

(a) RESIDENCE NO. *300-N-Mount*

(Usual place of abode)

Length of residence in city or town where death occurred *24* yrs. *0* mos. *0* ds.

REGISTERED NO. *129E 32874*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*

4 COLOR OR RACE *W*

5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *James A. Cuff*

6 DATE OF BIRTH (month, day, and year) *April 15, 1888*

7 AGE

Years *40*

Months *11*

Days *28*

If LESS than 1 day, ... hrs or ... min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Store*

(b) General nature of industry, business, or establishment in which employed (or employer) *Construction*

(c) Name of employer *James Brown*

9 BIRTHPLACE (city or town) (State or country) *James St. Co Md*

10 NAME OF FATHER *John Cuff*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *James St. Co Md*

12 MAIDEN NAME OF MOTHER *Ellen Corby*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *James St. Co Md*

14

Informant (Address) *Josiah A. Cuff*

15

Filed

*15 1928*

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-13* 19 *28*

17

HEREBY CERTIFY, That I attended deceased from *12* to *April 13* 19 *28*

that I last saw him alive on *April 12* 19 *28*

and that death occurred, on the date stated above, at *300 N-M*

The CAUSE OF DEATH\* was as follows:

*Ch + uremic chondros  
nephros*

CONTRIBUTORY (Secondary) *Michael* yrs. *4* mos. *1* ds.

18 Where was disease contracted if not at place of death? *at place of*

Did an operation precede death? *No*

Was there an autopsy? *No*

What test confirmed diagnosis? *Autopsy*

(Signed) *W. H. Jackson*

19

(Address) *409 N-Mount St*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Marion Md*

DATE OF BURIAL

20 UNDERTAKER

*4-17* 19 *28*

ADDRESS

*Joseph A. Lively 409 N-Mount St*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32875

## CERTIFICATE OF DEATH.

128 E 32875

### 1. PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Agnes Hospital* ST. *15-77* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Miss Josephine Cierniak*

(a) RESIDENCE NO. *24 Hazel St. Center Bay* ST. *15-77* WARD

(Usual place of abode)  
Length of residence in city or town where death occurred

Yrs. Mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? Yrs. Mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) *Unknown*

8 AGE Years Months Days If LESS than 1 day, hrs. or min. *19*

### 9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Packer in factory*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) *Md.*

11 NAME OF FATHER *Andrew Cierniak*

12 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*

13 MAIDEN NAME OF MOTHER *Unknown*

14 BIRTHPLACE OF MOTHER (city or town) (State or country) *Poland*

15 Informant (Address) *M. Cierniak 24 Hazel St.*

Filed

HANSON JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 13 1928*

17 I HEREBY CERTIFY, That I attended deceased from *4-10-28*, 1928, to *4-13-28*, 1928, that I last saw her alive on *April 13 1928* and that death occurred, on the date stated above, at *11:40 p.m.*

The CAUSE OF DEATH\* was as follows:  
*uremia with acute congestion of lungs, due to myocardial failure*

CONTRIBUTORY (Secondary) *acute nephritis*

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Blood urea (high)*  
*Augustine P. Vondra*  
*St. Agnes Hosp.*

\*State the Disease causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Cross Cem*

DATE OF BURIAL *April 15 1928*

20 UNDERTAKER *J. W. Gzowski*

ADDRESS *1930 Eastern Ave*

E 32876

# HEALTH DEPARTMENT—CITY OF BALTIMORE

8.3 2876

92878 1

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S. Lakewood -3 WARD)

2-FULL NAME Louise Bode

(a) RESIDENCE NO. 525 S. Lakewood

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of

Arthur Bode

7 DATE OF BIRTH (month, day, and year)

Feb. 14, 1892

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

46

1

29

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

William Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Esther Woodhull

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Arthur Bode 525 S. Lakewood

PR 16 1928

COMMISSIONER OF HEALTH

### MEDICAL CERTIFICATE

16 DATE OF DEATH (month, day, and year) 19 28

17

I HEREBY CERTIFY, That I attended deceased from Feb 10, 19 28, to April 13, 19 28.

that I last saw him alive on April 13, 19 28.

and that death occurred, on the date stated above, at 10:30 AM.

The CAUSE OF DEATH\* was as follows:

Pneumonia Terminal Labor.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Septicemia of the Circulation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Feb 13, 19 28

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Stewart, M. D.

(Address) 904 N Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Parkwood Cem April 19 28

UNDERTAKER

ADDRESS

Wendell J. Huppel 300 S. Calhoun

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32877

## CERTIFICATE OF DEATH

REGISTERED NO. 74-001

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hill(a) RESIDENCE NO. 1226 Carrollton Ave St.      Ward     

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

malecoloredmarried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

411887

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto

10 NAME OF FATHER

Chas Hill

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

md

12 MAIDEN NAME OF MOTHER

Clara Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md

14

Informant (Address)

Josephine Hill  
1226 Carrollton Ave

15 Filed

R 16 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/28 19

17

I HEREBY CERTIFY, That I attended deceased from

4/13/28, 19, to 4/13/28, 19,that I last saw him alive on 4/13/28, 19,and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

Respiratory Failure

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yesWhat test confirmed diagnosis? Clinical

(Signed)

, 19

(Address)

M. D.

Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt. Auburn4-16-28

20 UNDERTAKER

ADDRESS

John H. Treadwell



E 32878

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32878

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1500 W. Fayette

ST.: 19-27 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian D. Baker

(a) RESIDENCE. No. 1500 W. Fayette

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edmond G. Baker

6 DATE OF BIRTH (month, day, and year) Mar 4, 1877

7 AGE Years 51 Months 1 Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Dayton Ohio

10 NAME OF FATHER

Henry Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Dayton Ohio

12 MAIDEN NAME OF MOTHER

Marion

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Dayton Ohio

14

Informant (Address)

Emily A. Jones 1119 1st Street St

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jul 15, 1928 to April 14, 1928

that I last saw him alive on April 14, 1928

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Breast and Lungs

(duration) 2 yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) 7 yrs. 7 mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of op. 15-28

Was there an autopsy? No

What test confirmed diagnosis? X-Ray, Tumor study

(Signed) Arthur W. Kelly, M.D.

19 (Address) 1412 Light St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet

Apr 17 1928

20 UNDERTAKER

ADDRESS

Wm. Cook

500 E. North Ave.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32879

## CERTIFICATE OF DEATH.

E 32879

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 129 WARD 27)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Mabel West

### (a) RESIDENCE NO.

502 E North St.

### WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

#### 4 COLOR OR RACE

#### 5 Single, Married, Widowed, or Divorced, (write the word)

Female white

single

#### 5a If married, widowed, or divorced HUSBAND of or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

Mar 14, 1910

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

18

1

1

#### 8 OCCUPATION OF DECEASED

##### (a) Trade, profession or particular kind of work

none

##### (b) General nature of industry, business, or establishment in which employed (or employer)

##### (c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

in Maryland

#### 10 NAME OF FATHER

Christopher West

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York

#### 12 MAIDEN NAME OF MOTHER

Kathie Yeager

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

#### 14

Informant (Address)

W. H. Jones

#### 15

APR 16 1928

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

4/10/1928

#### 17

I HEREBY CERTIFY, That I attended deceased from

Apr. 14, 1928 to Apr. 15, 1928

that I last saw him live on Apr. 15, 1928

and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(duration) yrs. 4 mos. ds.

#### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

#### 18 Where was disease contracted? if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Sub

(Signed) C. J. Jones, M. D.

. 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-

#### DATE OF BURIAL

St. Charles

Apr 18 1928

#### 20 UNDERTAKER

W. M. Cook

ADDRESS

502 E North St.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32880

## CERTIFICATE OF DEATH.

46 E 32880

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3804 Barrington Rd. ST. 5-63)

2. FULL NAME Gertrude Ware

(a) RESIDENCE No. 3804 Barrington Rd. ST. 5-63

(Usual place of abode)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

white

widow

6a If married, widowed, or divorced HUSBAND of or WIFE of

Joseph Ware

7 DATE OF BIRTH (month, day, and year)

Feb. 8, 1882

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

46

2

6

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Examiner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Chicago Ill.

10 NAME OF FATHER

Marion Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Laura King

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Wm T Perkins  
3804 Barrington Rd.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 14, 1928

17

I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1927 to April 14, 1928, that I last saw her alive on April 12, 1928, and that death occurred, on the date stated above, at 2.00 A m. The CAUSE OF DEATH\* was as follows:

Exhaustion

(duration)

ys.

mos.

ds.

CONTRIBUTORY (Secondary)

Carcinoma of uterus

(duration)

1 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

yes Date of Aug 1927

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Reboulton

M. D.

4/14, 1928 (Address)

3909 Garrison Blvd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

APR 16 1928

Registrar

Wm C. Oat  
102 E. North

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32881

## CERTIFICATE OF DEATH.

31 E 32881

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals (T. 9-116 ST., WARD)

2-FULL NAME Robert Clemens

(a) RESIDENCE No. 637 Walpert ave.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ST., WARD (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of or WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE 49 Years Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Ed. Clemens

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records (Address)

15

APR 16 1928 REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 13, 1928

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1928 to April 13, 1928

that I last saw him alive on April 13, 1928

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) J. M. Madden, M. D.

4-13-1928 Address Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Pulmonary

Apr 16 1928

20 UNDERTAKER

ADDRESS

Coah

512 E. Main St.



E 32882

HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *118* St. *17* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *1876 Bethel St.* St. *17* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *80* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White**Widowed*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *not known*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day... hrs.  
or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 F. 19

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

*4-7, 1928, to 4-14, 1928*that I last saw him alive on *4-14, 1928*and that death occurred, on the date stated above, at *10:00 A.M.*

The CAUSE OF DEATH\* was as follows:

*Acute intestinal obstruction  
due to strychnine  
intestinal hernia*(duration) yrs. mos. ds. *2*CONTRIBUTORY  
(Secondary)(duration) yrs. mos. ds. *5*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes*Date of *4-7-28*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in death from Violence, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

APR 16 1928

R. M. Registrar

*W. H. Cook**Apr 17 1928  
502 E. North Ave*

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32883

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital 9-45* WARD)

## 2-FULL NAME

*Grace Irene Thomas*

## (a) RESIDENCE NO.

*Haiter, Carroll Co., Md.*

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Nov. 4, 1925*

## 7 AGE

Years

Months

Days

If LESS than

*2**5**10*

1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

*None*

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Haiter, Carroll Co., Md.*

## 10 NAME OF FATHER

*Elias John Thomas*

## 11 BIRTHPLACE OF FATHER (city or town)

*Haiter, Carroll Co., Md.*

## 12 MAIDEN NAME OF MOTHER

*Alma Murray*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Deer Park, Baltimore Co., Md.*

## 14

Informant (Address)

*Mrs. Alice Thomas, Haiter, Md.*

## 15

SIGNATURE OF REGISTRAR

PR 16 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*April 15, 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*April 14, 1928, to April 15, 1928.*that I last saw her alive on *April 14, 1928.*and that death occurred, on the date stated above, at *905 a.m.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*(duration) yrs. mos. *6* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

*At home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*None*(Signed) *J. L. Levin*, M. D.4-15, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

*Greenwood Md. April 16, 1928*

## BURIAL

## ADDRESS

*Greenwood Md. Sydenham*

Valenzi  
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 12-51)

2-FULL NAME Anthony J. Valenzi

(a) RESIDENCE NO. 410 Glen Edwards ST.

(Usual place of abode)  
Length of residence in city or town where death occurred

ys. mos. ds.

How long in U. S., if of foreign birth?

WARD City

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

3-15-27

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

13

29

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind -

10 NAME OF FATHER

John Valenzi

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Rosi Muzinani

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Records -

15

Filed

JOHNS HOPKINS HOSPITAL

JONES, R.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 14 1928

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1928, to April 14, 1928, that I last saw him alive on April 14, 1928, and that death occurred, on the date stated above, at 10 20 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive nasal culture

(Signed) Helen Blosson, M. D.

19 (Address) The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Edwards Jones

4/16 1928

UNDERTAKER

ADDRESS

Edward Jones

247 2nd

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32885

## CERTIFICATE OF DEATH.

129  
E 32885  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 Hamilton Ave.ST. 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie L. Bailey(a) RESIDENCE NO. 2113 Hamilton Avenue.ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Adam I. Bailey6 DATE OF BIRTH (month, day, and year) Feb. 9, 18597 AGE Years 69 Months 2 Days 4 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)10 NAME OF FATHER James Jones11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.12 MAIDEN NAME OF MOTHER Ruth Ball13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14

Informant Jerry Bailey (Address) 2113 Hamilton Ave.

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 15<sup>th</sup>, 1928, to April 13<sup>th</sup>, 1928. That I last saw him alive on April 13<sup>th</sup>, 1928.and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH\* was as follows:

Nephritis(duration) yrs. 3 mos. — ds.CONTRIBUTORY Uremia (Secondary)(duration) yrs. 1 mos. — ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? ✓ Date of —Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Robert S. Kirk, M. D.4/14/28 (Address) 3126 Harford Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Weisburg, Balto., Co.Apr. 16, 1928

20 UNDERTAKER

ADDRESS

E. Leroy Stiffler135 E. 1st St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32886

## CERTIFICATE OF DEATH.

74-091  
15-63  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3825 Kate Ave.

## 2-FULL NAME

Henry Hofmann.

## (a) RESIDENCE NO.

3825 Kate Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

68 yrs. 5 mos. 0

ST.

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male.

4 COLOR OR RACE

White.

5 Single, Married, Widowed, or Divorced. (write the word)

Married.

5a If married, was HUSBAND of  
WIFE of  
Emma S. Hofmann.

6 DATE OF BIRTH (month, day, and year)

November 13, 1859

7 AGE

Years

Months

Days

68

5

0

If LESS than  
1 day.....hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upper manufacturer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER Christopher Hofmann.

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Schwoerer

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany.

14 Informant Emma S. Hofmann. (wife)  
(Address) 3825 Kate Ave.15 Filed 1928 HARRISON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1928

17 I HEREBY CERTIFY, That I attended deceased from  
December 1, 1925 to April 13, 1928that I last saw him alive on April 13, 1928  
and that death occurred, on the date stated above, at 12.40 p. m.The CAUSE OF DEATH\* was as follows:  
Cerebral Hemorrhage.  
Hemiplegia.(duration) 2 yrs. 4 mos. 12 ds.  
CONTRIBUTORY (Secondary) Acute dilatation of the  
Heart18 Where was disease contracted  
(duration) yrs. mos. 1 ds.  
if not at place of death? -----

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.  
(Signed) Otto M. Reinhardt M. D.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

London Park Cemetery Co. April 16, 1928

20 UNDERTAKER

ADDRESS

John F. Denny 715 Light St

E 32887

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 N. Arlington Ave. ST. 18-76 WARD)

2-FULL NAME Sarah Patterson Vane

(a) RESIDENCE NO. 510 N. Arlington Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of William A. Vane (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 29 1839

7 AGE Years 88 Months 7 Days 17 If LESS than 1 day, hrs or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

10 NAME OF FATHER James Fooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marg't Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant W.B. Vane (Address) 337 Warren Ave.

15 PR 16 1928 REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan-10, 1927, to April 15, 1928, that I last saw her alive on April-14, 1928,

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? m Date of

Was there an autopsy? m

What test confirmed diagnosis? none (Signed) E. Gill Hall M. D.

April 1927 (Address) 1631 E. North

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cambridge Md - Via B. & O. RR

April 16 1928

20 UNDERTAKER John P. Denny

ADDRESS 715 Light St



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32889

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: No. Baltimore City Hospitals ST. 15 WARD 21

### 2-FULL NAME Vernon Stepney

(a) RESIDENCE No. 1850 Lorman st.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

ST. 15 WARD 21

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 31 E 32889

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or WIFE of --

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE Years 6 Months Days 1 LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work --

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Harry Stepney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Letha Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15

R 16 1928

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1928

17 I HEREBY CERTIFY, That I attended deceased from March 7 19 28 to April 14 19 28, that I last saw him alive on April 14 19 28, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:  
Pulmonary Tuberculosis  
Unknown

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Madden, M. D.

4-14-28 Address Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



E 32890

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 ✓ E 32890

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3302 Taylor Ave. St. 27-43 Ave.)

2-FULL NAME Mildred Elizabeth Wise

(a) RESIDENCE NO. 3302 Taylor Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 4 mo. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Wm. Henry Wise

6 DATE OF BIRTH (month, day, and year)

Nov. 25, 1901

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

26

4

17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country)

Md.

10 NAME OF FATHER Grant Guisewhite

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Penna.

12 MAIDEN NAME OF MOTHER

Elizabeth Schulbe

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14 Informant Wm. Henry Wise

(Address)

3302 Taylor Ave.

APR 15 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1928

17

I HEREBY CERTIFY, That I attended deceased from

1924 to April 12, 1928,

that I last saw him alive on April 12, 1928,

and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY Tubercular peritonitis

(Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death

don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) J. M. B. Leon, M. D.

4/14, 1928 (Address) Parkville, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Parkwood Cem.

Apr. 16 1928

20 UNDERTAKER

ADDRESS

Mrs. Albert C. Fuller 4804 Harford Ave.

E 32891

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

89 E 32891

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 6240 Bellona ave 27-48 WARD)

2-FULL NAME Randolph J Richards

(a) RESIDENCE NO. 6240 Bellona ave  
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 9 mos. 20 ds. ST.        WARD         
(If non-resident give city or town and State)

REGISTERED NO.         
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Susan K Richards

DATE OF BIRTH (month, day, and year) July 25th 1853  
AGE Years 74 Months 9 Days 20 LESS than 1 day, hrs.        or min.       

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brain Mechanic  
(b) General nature of industry, business, or establishment in which employed (or employer)         
(c) Name of employer       

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Md

10 NAME OF FATHER Edward Richards

11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Richards

13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)

14 Informant Charles K Richards  
(Address) 6240 Bellona ave

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 1928

17 I HEREBY CERTIFY, That I attended deceased from on April 14, 1928 to April 14, 1928  
that I last saw him alive on April 14, 1928  
and that death occurred, on the date stated above, at 5:45 P. m.  
The CAUSE OF DEATH\* was as follows:

Angina Pectoris.

CONTRIBUTORY (Secondary) Infection (duration) yrs. 3 mos.        ds.

18 Where was disease contracted if not at place of death?       

Did an operation precede death? No Date of       

Was there an autopsy? No

What test confirmed diagnosis?         
(Signed) Dr J Hec King M. D. Address 5835 York Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL       

DATE OF BURIAL April 17 1928

20 UNDERTAKER Hedge Schilling & Sons

ADDRESS 11202 Monument

PR 16 1928

32892

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 32892

### 1-PLACE OF DEATH

CITY OF BALTIMORE, No. *St. Agnes Hosp.* ST. *25-72* WARD

### 2-FULL NAME

*Mrs. Marie Bushong*

### (a) RESIDENCE NO.

(Usual place of abode)

*Green Arm Balto Co Md* ST. WARD

Length of residence in city or town where death occurred

Yrs. *17* ds.

How long in U. S., if of foreign birth? (If non-resident give city or town and State) Yrs. *—* mos. *—* ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

*Female*

#### 4 COLOR OR RACE

*White*

#### 5 Single, Married, Widowed, or Divorced, (write the word)

*married*

#### 5a If married, widowed, or divorced

(or) WIFE of

*Hubbard Bushong*

#### 6 DATE OF BIRTH (month, day, and year)

*July 18, 1885*

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*42*

*8*

*26*

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

*Maryland*

#### 10 NAME OF FATHER

*John Fuschmeier*

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Prussia*

#### 12 MOTHER'S NAME OF FATHER

*Elizabeth Offeder*

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Prussia*

#### 14

Informant

(Address)

*Hubbard Bushong*  
*Green Arm Balto. Md*

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

*4-13* 19 *28*

#### 17

I HEREBY CERTIFY, That I attended deceased from *3-27*, 19 *28*, to *4-13*, 19 *28*.

that I last saw *her* alive on *4-13*, 19 *28*

and that death occurred, on the date stated above, at *5 A. M.*

The CAUSE OF DEATH\* was as follows:

*Syphilitic aortic*

(duration)

Yrs.

Mos.

Ds.

#### CONTRIBUTORY (Secondary)

*Coronary Arteriosclerosis*

(duration)

Yrs.

Mos.

Ds.

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *yes*

What test confirmed diagnosis?

*Augustine P. Von Schryg M. D.*  
*St. Agnes Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

*Green Mount Cemetery* *April 16, 1928*

#### 20 UNDERTAKER

ADDRESS

*H. H. Westport, 1850 N. Bacco St*

FILED 16 1928

G. H. HARRIS, Registrar

E 32893

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Sydenham Hospital 14-28* ST. WARD)2-FULL NAME *Edward P. Scriba*(a) RESIDENCE NO. *1845 Ramsay St*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

ST. WARD

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 20, 1926*  
7 AGE Years Months Days *25* If LESS than 1 day, hrs. or min. *2 0 26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto. Md*10 NAME OF FATHER *Edw. P. Scriba*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto*12 MAIDEN NAME OF MOTHER *Mary Kessler*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto*14 Informant *Edw. P. Scriba*  
(Address) *1845 Ramsay St*15 Filed *19* REGISTRAR *W. B. Wofford*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 15 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 2, 1928*, to *April 15, 1928*, that I last saw him alive on *April 15, 1928*, and that death occurred, on the date stated above, at *11 25 a m.*

The CAUSE OF DEATH\* was as follows:

*Tonsillar Diphtheria*CONTRIBUTORY (duration) yrs. mos. ds. *15*  
(Secondary) *Retropharyngeal Abscess*18 Where was disease contracted (duration) yrs. mos. ds. *2*  
if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical & pos. Cultures*  
(Signed) *Myron E. Tull*, M. D.4/16, 1928 (Address) *Sydenham Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REINTERMENT DATE OF BURIAL

*Woodlawn Burial Cemetery* *April 17/28*  
UNDERTAKER *W. B. Wofford* ADDRESS *1850 W. Balto*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32894

## CERTIFICATE OF DEATH.

E 32894

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *18 N. Clinton* ST., *26* WARD)2-FULL NAME *Gerald Snyder*(a) RESIDENCE NO. *18 N. Clinton*

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *1* mos. *16* ds.ST., *26* WARD

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 28, 1927*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1* *1* *16*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*None*9 BIRTHPLACE (city or town) (State or country) *Baltimore md*10 NAME OF FATHER *Miles Snyder*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore md*12 MAIDEN NAME OF MOTHER *Helen Jordan*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore md*

14

Informant (Address) *Miles Snyder*  
*18 N. Clinton St.*

15

Filed *1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 15, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 12, 1928*, to *April 15, 1928*, that I last saw him alive on *April 15, 1928*, and that death occurred, on the date stated above, at *2:45 A.M.*

The CAUSE OF DEATH\* was as follows:

*Measles & Bronchopneumonia*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clin. data*(Signed) *L. S. H. Lang*

M. D.

, 19 (Address) *3034 E. Baltimore St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Mount Carmel Cemetery**April 16, 1928*

20 UNDERTAKER

*Lilly Zeiler Inc*

ADDRESS

*4038 Woodlawn*

32895

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## I. PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3717 Mt Pleasant ST., No 37 WARD)

## 2. FULL NAME Bernard Fuchsleger

(a) RESIDENCE NO. 3717 Mt Pleasant

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 9 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 30 1927

7 AGE

Years

Months

Days

9

15

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Michael Fuchsleger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Laura Vorrath

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Michael Fuchsleger 3717 Mt Pleasant St. Baltimore Md

15

APR 16 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 14 1928

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1928, to April 14, 1928, that I last saw him alive on April 14, 1928,

and that death occurred, on the date stated above, at 2:55 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration)

yrs.

mos. 6

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 3

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Chest X-ray

(Signed)

J. Fuchsleger, M. D.

, 19 (Address)

3031 Bulevar

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sacred Heart Cemetery

April 16 1928

20 UNDERTAKER

Lilly &amp; Ziller Inc.

ADDRESS

403 S. Wolfe St.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32896

## CERTIFICATE OF DEATH.

90 E 32896

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 11-24 WARD)

2-FULL NAME Jenny Bunker

(a) RESIDENCE NO. 302 Shadow Lane WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widowed  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jenny Bunker  
6 DATE OF BIRTH (month, day, and year) Aug 3 1844  
7 AGE Years 73 Months 8 Days 1 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

### 9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Records

15 Filed 1923 REGISTRAR W. H. H.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15/1928

17 I HEREBY CERTIFY, That I attended deceased from Aug 23 1898 to Apr. 15 1928 that I last saw him live on Apr. 10 1928 and that death occurred, on the date stated above, at 10:40 A. m.

The CAUSE OF DEATH\* was as follows:  
Myocarditis, caninus acute  
arteriosclerosis  
hypertension  
(duration) ? yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds. 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Sub  
(Signed) C. Helms George, M. D.

19 (Address) BALTIMORE CITY HOSPITAL  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Mathias  
German  
7th Ave

### DATE OF BURIAL

4/17/28

### ADDRESS

507 E. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32897

## CERTIFICATE OF DEATH.

101-001  
E 32897

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3646 Beech Ave. 13-52 WARD)2-FULL NAME Walter F. Leard.(a) RESIDENCE NO. 3646 Beech Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.6 DATE OF BIRTH (month, day, and year) Feb 1, 19267 AGE Years 2 Months 1 Days 13 If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto10 NAME OF FATHER Walter F. Leard11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto12 MAIDEN NAME OF MOTHER Victoria Strone13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14

Informant (Address) Walter F. Leard

15

Filed

1926

D.

JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 13, 1928, to Apr 14, 1928, that I last saw him alive on Apr 14, 1928, and that death occurred, on the date stated above, at 2:45 P.M. m.

The CAUSE OF DEATH\* was as follows:

Solar Pneumonia(duration) to not known yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? noWhat test confirmed diagnosis? Routine(Signed) W. H. Deidinger, M. D., 19 (Address) 550 N. 36 St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Poplar Balto Co.

DATE OF BURIAL

20 UNDERTAKER ShenowethADDRESS 3615 Ch...



E 32898

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital 21-31* WARD)2-FULL NAME *James Johnson, Jr.*(a) RESIDENCE NO. *804 China*(Usual place of abode)  
Length of residence in city or town where death occurred

ST. \_\_\_\_\_ WARD \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32898

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year) *May 16, 1927*7 AGE Years *0* Months *11* Days *0* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*10 NAME OF FATHER *James Johnson*11 BIRTHPLACE OF FATHER (city or town) *Baltimore*  
(State or country) *Md.*12 MAIDEN NAME OF MOTHER *Elle Williams*13 BIRTHPLACE OF MOTHER (city or town) *Charlotte*  
(State or country) *N. Carolina*14 Informant *Mrs. Elle Johnson*  
(Address) *546 Wickham Ave.*15 Filed *18* 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 15, 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 12, 1928* to *April 15, 1928*, that I last saw him alive on *April 15, 1928*, and that death occurred, on the date stated above, at *100 p. m.*

The CAUSE OF DEATH\* was as follows:

*Pertussis*CONTRIBUTORY (Secondary) *Bronchopneumonia* (duration) yrs. mos. *9* ds.18 Where was disease contracted if not at place of death? *At home* (duration) yrs. mos. *7* ds.Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *None*(Signed) *J. L. Levin* M. D.4-15, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Mount Zion* 4-16 1928

20 UNDERTAKER

ADDRESS

*Joseph A. Lively 4094 Mount*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32899

## CERTIFICATE OF DEATH.

129 E 32899  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Brint ST. 14-20 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1720 Brint ST. 14-20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER\* (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13 19 28

17

I HEREBY CERTIFY, That I attended deceased from Mar 8, 1928, to April 13, 1928.that I last saw him alive on April 12, 1928.and that death occurred, on the date stated above, at 12:10 A m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Urinary(Signed) G. McLean, M. D.4-16 1928 (Address) 1126 Druid Hill

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

11th Ambrose Ave. 4-16-2810 UNDERTAKER Samuel H. Hensley ADDRESS 11th Ambrose Ave.

32900

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 129 E 32900

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1013 Rice, St. 16-23 Ward)2-FULL NAME Horace G. Williams(A) RESIDENCE NO. 1013 Rice St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 00 mos. 00 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Wol 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of Alice Williams (or) WIFE of6 DATE OF BIRTH (month, day, and year) June 7-18987 AGE Years 28 Months 10 Days 7 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Miss. (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Miss. (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Miss. (State or country)14 Informant Alice Williams (Address) 1013 Rice15 Filed 1928 6 HALPERN Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said Inquest, au- (Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Interstitial Nephritis  
(duration) one yrs. 00 mos. 00 ds.

## CONTRIBUTORY (Secondary)

(duration) Feb. 28 yrs. 00 mos. 00 ds.(Signed) John L. Quinn M. D.(Coroner) John L. Quinn

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Auburn Cem Date of Burial 4/16/2820 UNDERTAKER Henry M. Brink ADDRESS 178

E 32901

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32901

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2406 Fait Ave

St. 1-3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME STANISLAUS A. BUNK,

(a) RESIDENCE NO. 2406 Fait Ave

(Usual place of abode)

St. Ward

Length of residence in city or town where death occurred 29 yrs. 7 mos. 6 ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Cecilia Bunk,

6 DATE OF BIRTH (month, day, and year)

Sept., 8-1898.

7 AGE

Years

Months

Days

IF LESS than  
1 day... hrs.  
or... min..

29

7

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wood box factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

DIXIE Duker's

9 BIRTHPLACE (city or town)

Baltimore,

(State or country)

MD.

10 NAME OF FATHER

Anton Bunk,

11 BIRTHPLACE OF FATHER (City or town)

German

(State or country)

Poland,

12 MAIDEN NAME OF MOTHER Rozalia Barzynska,

13 BIRTHPLACE OF MOTHER (city or town)

German

(State or country)

Poland,

14

Informant

Mrs. Cecilia Bunk, (Wife)

(Address)

2406 Fait Ave

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

April - 14 / 1928

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 8, 1926, to April 14, 1928

that I last saw him alive on April 14, 1928

and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No

Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19

(Address)

2942 E. Fayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Holy Rosary

M. J. Sadowski

Apr. 18, 1928

705 S. Lomb

very important. See instructions on back of certificates.

APR 16 1928 HANSON JONES, M. Registrar





32903

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital 13-54*)2-FULL NAME *Mary Miller*(a) RESIDENCE NO. *2814 Woodbrook Ave.*

(Usual place of abode)

Length of residence in city or town where death occurred *Life*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *—*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *May - 1926*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *—*(b) General nature of industry, business, or establishment in which employed (or employer) *—*(c) Name of employer *—*9 BIRTHPLACE (city or town) (State or country) *Balto., Ind.*10 NAME OF FATHER *Ellis Miller*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*12 MAIDEN NAME OF MOTHER *Ethel H. Miller*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14

Informant (Address) *Ellis Miller 2814 Woodbrook Ave.*

R 16 1928

G. HANSON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/16/28* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *4/1/28*, 19 *28*, to *4/16/28*, 19 *28*, that I last saw her alive on *4/15/28*, 19 *28*, and that death occurred, on the date stated above, at *5:45 A.M.*

The CAUSE OF DEATH\* was as follows:

*Emphysema thoracica*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Lobar pneumonia*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *—*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Hamm G. Vozz*, M. D., 19 (Address) *St Joseph Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*St. Andrew Wash. Road**4-16-1928**Joe Lewis, 1434 E Balto. St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32904

## CERTIFICATE OF DEATH.

51 E 32904

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2509 Woodbr. Av. 13-59 Ward)2-FULL NAME Roland N. Keeney(a) RESIDENCE NO. 2509 Woodbr. Av. St. \_\_\_\_\_ Ward \_\_\_\_\_(Usual place of abode)  
Length of residence in city or town where death occurred 3 1/2 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Wht 5 Single, Married, Widowed, or Divorced, (write the word) \_\_\_\_\_5a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year)  
Sept. 26 / 19247 AGE Years Months Days 14 IF LESS than 1 day.....hrs. or.....min.  
3 6 20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Balti.  
(State or country) md.10 NAME OF FATHER Le Roy Keeney11 BIRTHPLACE OF FATHER (city or town) Fruit Co. Md.  
(State or country)12 MAIDEN NAME OF MOTHER Eva Reed13 BIRTHPLACE OF MOTHER (city or town) Balti. Co Md.  
(State or country)14 Informant Le Roy Keeney  
(Address) 2509 Woodbr. Av.15 Filled....., 19 C. H. LINDSON JONES, JR.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 15<sup>th</sup> 1928 19 2817 I HEREBY CERTIFY, That I attended deceased from Apr. 12<sup>th</sup> 1928, to Apr. 15<sup>th</sup> 1928, that I last saw him alive on Apr. 15<sup>th</sup> 1928, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH\* was as follows:

Rheumatism following  
(Rachitis)(duration) .....yrs. ....mos. 5 ds.  
CONTRIBUTORY Sudden failing of  
(Secondary) Heart action  
(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of.....Was there an autopsy? NOWhat test confirmed diagnosis? Visu(Signed) Edmund, M. D.4/5/28 (Address) 1605 W North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Resent Hill Cemetery Date of Burial Apr. 17 1928

UNDERTAKER

ADDRESS 27th St. & 12th W Lombard St

Very Important. See instructions on back of certificate.

E 32905

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32905  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Forty & Popple 16-22* St. *16-22* Ward)2-FULL NAME *Blanche Newton*(a) RESIDENCE NO. *2037 W. Lafayette* Ward(Usual place of abode) Length of residence in city or town where death occurred *5* yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Elmer C Newton* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Feb 12 - 1896*7 AGE Years *32* Months *2* Days *2* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) *Delaware*  
(State or country)10 NAME OF FATHER *E. Dietherson*11 BIRTHPLACE OF FATHER (city or town) *Del*  
(State or country)12 MAIDEN NAME OF MOTHER *Dorothy*13 BIRTHPLACE OF MOTHER (city or town) *Del*  
(State or country)14 Informant *Elmer C Newton*  
(Address) *2037 W. Lafayette*15 FILED *16* 1928 *G. H. [illegible]* Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 14 1928*17 I HEREBY CERTIFY that I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said *Inquiry* and that said deceased came to *Res* death on the day stated above.

The CAUSE OF DEATH was as follows:

*Vincent Angina*  
(duration) *Cardiac Disturbance* ds.CONTRIBUTORY *april 14* (Signed) *G. C. Blades* mos. ds. M. D.(Address) *143 W. 3rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION, OR REMOVAL *Del* Date of Burial *April 19 28*20 UNDERTAKER *John F. [illegible]* ADDRESS *1201 W. Lombard*

very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32906

## CERTIFICATE OF DEATH.

90 E 32906

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Beach alley WARD 23-31)2-FULL NAME Anna Lettan(a) RESIDENCE NO. 1111 Beach alley

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds.WARD 23-31

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3, SEX F4 COLOR OR RACE W.5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Lettan6 DATE OF BIRTH (month, day, and year) 1875

7 AGE

Years 53

Months

Days

If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denmark10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14

Informant (Address) August Lettan

15

G. HAMMON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1928

17

I HEREBY CERTIFY, That I attended deceased from March 15<sup>th</sup>, 1928, to April 14<sup>th</sup>, 1928, that I last saw him alive on April 13<sup>th</sup>, 1928, and that death occurred, on the date stated above, at 3.4 m.

The CAUSE OF DEATH\* was as follows:

Acute Incompetency(duration) yrs. 1 mos. 0 ds.CONTRIBUTOR (Secondary) Acute dilatation of heart(duration) yrs. 1 mos. 0 ds.18 Where was disease contracted if not at place of death? at place of deathDid an operation precede death? No Date of     Was there an autopsy? NoWhat test confirmed diagnosis? Physical Examinations(Signed) H. H. Leibel M. D.4/16, 1928 (Address) 1224-26 Hanover St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-  
MOVAL Bowdoin Park

DATE OF BURIAL

20 UNDERTAKER William CookADDRESS 502 E. North

R 16 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32907

## CERTIFICATE OF DEATH.

REGISTERED NO. 84 E 32907

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 7-9 Ward)2-FULL NAME Helen H. Paine(a) RESIDENCE NO. 35 W. 35th St Jacksonville Fla Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) Married/ widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John W. Paine

6 DATE OF BIRTH (month, day, and year)

July 5/1872

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
55 9 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Canada10 NAME OF FATHER John Holmes

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Scotland12 MAIDEN NAME OF MOTHER Margaret Shields

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

New York State14 Informant Miss Jessie Holmes

(Address)

Jacksonville, Fla.15 Filed 1928, 19C. H. Holmes

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Glial Tumor Rt. Cerebral Cortex.

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [Signature] M. D.

(Coroner)

4/16/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Jacksonville Fla Apr 16 1928

UNDERTAKER

ADDRESS

John O Mitchell Son 1900 Calumet

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001E 32908

E 32908

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 12-14 Ward)2-FULL NAME Mattie L. Wright(a) RESIDENCE NO. 1608 Guilford ve St.        Ward       

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofE lex . Wright6 DATE OF BIRTH (month, day, and year) May /18827 AGE 45 Years Months 11 Days IF LESS than I day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.  
(State or country)10 NAME OF FATHER Gerome O'Leary11 BIRTHPLACE OF FATHER (city or town) Balto., Md.  
(State or country)12 MAIDEN NAME OF MOTHER Celeste Miller13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.  
(State or country)14 Informant Mrs Mary E. French  
(Address) 1508 Guilford Ave15 Filed 1928 19        H.        JONES, R.         
RegistrarREGISTERED NO.       

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-topsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Autopsy)

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)(Signed)        M. D.  
(Coroner)(Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Menns and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park Cem Apr 17 1928

20 UNDERTAKER

John O Mitchell Sons 1708 E. Calver  
Place

Very Important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32909

## CERTIFICATE OF DEATH.

129 E 32909  
REGISTERED NO.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 W. Baltimore ST., 18-76 WARD)

2. FULL NAME Mary Evans

(a) RESIDENCE NO. 824 W. Baltimore ST., 18 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert N. Evans

6 DATE OF BIRTH (month, day, and year) May 30, 1857

7 AGE Years 70 Months 10 Days 16 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER John T. Ways

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Harriet A. Buckner

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Howard N. Jenkins (Address) 824 W. Baltimore St.

15 Filled APR 15 1928 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15/28

17 HEREBY CERTIFY, That I attended deceased from 4/12/28 to 4/15/28 that I last saw him alive on 4/14/28 and that death occurred, on the date stated above, at 8:40 a. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY (Secondary) Cholelithiasis (duration) yrs. mos. ds. 15

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Jones, M. D. (Address) 575 S. Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgan M. E. Cemetery, Carroll Co., Md.

DATE OF BURIAL

Apr. 17 1928

20 UNDERTAKER

ADDRESS

1003 West Baltimore St.



E 32910

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

✓  
101 E 32910

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 N. Milton Ave

ST. 8-16 WARD

2-FULL NAME Catherine A. Legg

(a) RESIDENCE No. 1331 N. Milton Ave

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles E. Legg

6 DATE OF BIRTH (month, day, and year)

Oct. 4-1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

6

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Wilson Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto, Md.

12 MAIDEN NAME OF MOTHER

Grace Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto, Md.

14

Informant (Address)

Ida B. Legg

15

Filed

G. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 19 28

17

I HEREBY CERTIFY, That I attended deceased from 4/5/28, 19 28, to 4/14/28, 19 28,

that I last saw him alive on 4/14/28, 19 28, and that death occurred, on the date stated above, at 11:55 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 10 ds. Cardiac decompensation

18 Where was disease contracted if not at place of death?

(duration) yrs. mos. 1 ds.

Did an operation precede death?

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

none

(Signed) Geo. A. Snowden, M. D.

(Address) 1517 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Olivet Cemetery

20 UNDERTAKER

George W. Girkler

DATE OF BURIAL

April 18 19 28

ADDRESS

1737 E. Egan St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32911

E 32911

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 N Port ST., 6-10 WARD)2-FULL NAME Theresa Armiger(a) RESIDENCE NO. 222 N Port ST., 6-10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

ST., WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE W5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Armiger6 DATE OF BIRTH (month, day, and year) Dec 25, 1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54319

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Joseph Boyner11 BIRTHPLACE OF FATHER (city or town) (State or country) Md12 MAIDEN NAME OF MOTHER Wilhelmina Wolf13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14

Informant (Address) John H Armiger  
222 N Port St

15

Filed 1928

19

C. HANFORD JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1928

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1928, to April 14, 1928.that I last saw him alive on April 14 1928.and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis  
Art. Arterial HypertensionDuration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral Embolism  
Hypertension 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Jones M. D.19 (Address) #156 N. Melton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

BaltimoreApr 17 1928

20 UNDERTAKER

ADDRESS

W. H. Cook302 E North Ave

E 32912

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32912

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2452 Druid Hill Ave. 3-59)

ST.

WARD)

## 2. FULL NAME

Ida Schochet

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2452 Druid Hill Ave

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

10

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

Philip Schochet

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Minkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Philip Schochet 2432 Druid Hill Ave

15

Filed

1928

19

BALTIMORE

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/16

19

28

17

I HEREBY CERTIFY, That I attended deceased from

Apr 11

19 28

to Apr 15

19 28

that I last saw him alive on

Apr 14

19 28

and that death occurred, on the date stated above, at

8 a m.

The CAUSE OF DEATH\* was as follows:

Aortic + mitral Regurg.  
Auricular Fibrillation

(duration)

2

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Chronic Bronchitis

(duration)

4

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Chemical + laboratory

(Signed)

A. F. Reis

M. D.

Apr 15, 1928 (Address)

24 Druid Hill Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Heaven Mt Carmel

4/16 19 28

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32913

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *408 Edgewood* ST. *20-70* WARD)2-FULL NAME *"Baby" Bunda*(a) RESIDENCE NO. *408 Edgewood*  
(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Female**white**Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Apr 12-1928*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

*Child*9 BIRTHPLACE (city or town)  
(State or country)*Balto*

10 NAME OF FATHER

*Michael John Bunda*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Penn.*

12 MAIDEN NAME OF MOTHER

*Bessie King*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Calcutta, Ind.*

14

Informant  
(Address)*Mr. Michael J. Bunda  
408 Edgewood St*

15

Filed

19

2365

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 14 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Apr. 13*, 19*28*, to *Apr. 14*, 19*28*,that I last saw him alive on *Apr. 14*, 19*28*and that death occurred, on the date stated above, at *2:30 P.* m.

The CAUSE OF DEATH\* was as follows:

*Premature Birth*(duration) yrs. *6* mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Paul Brown*, M. D.413, 1928 (Address) *1837 Penna Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

19

19 UNDERTAKER

ADDRESS

Commissioner Health.

APR 16 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32914

E 32914

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 S. Garrison Lane ST. 70-69 WARD)

2-FULL NAME Elizabeth Hettche

(a) RESIDENCE NO. 27 S. Garrison Lane

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)  
Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

John Hettche

6 DATE OF BIRTH (month, day, and year) May 17, 1853

7 AGE

Years

Months

Days

74

11

29

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant Mr. Sidney Q. Mercier  
(Address) 27 S. Garrison Lane

6 1828 C. HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 5, 1928, to April 15, 1928,  
that I last saw her alive on April 15, 1928,  
and that death occurred, on the date stated above, at 8:50 P. M.

The CAUSE OF DEATH\* was as follows:

Arterial Sclerosis hypertension

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Blod Quaker &  
Chas A. Quaker, M. D.  
2105 W. Baltimore St.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Baltimore Cemetery

DATE OF BURIAL

Apr. 18, 1928

ADDRESS

1003 West  
Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

32915

## CERTIFICATE OF DEATH.

90 E 32915

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Whitelock ST. 13-59 WARD)2-FULL NAME Mary Levin(a) RESIDENCE NO. 813 Whitelock

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds.ST., 13-59 WARD

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? 20 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (Write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6 1898

7 AGE

Years 30Months 1Days 10

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W. Va10 NAME OF FATHER Louis Levin11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Yetta Borman13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant Louis Levin  
(Address) 813 Whitelock St

15

Filed 1928

19

HARRISON JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1928

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1928 to April 16, 1928.that I last saw h. alive on April 16, 1928.and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH\* was as follows:

acute bronchitis.(duration) yrs. mos. 7 ds.CONTRIBUTORY (Secondary) mitral stenosis(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Levin, M. D.Address 1810 Euter Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Washington Rd

20 UNDERTAKER

Al. Levinson & Bro

DATE OF BURIAL

4/17 1928ADDRESS 1127 E Balto St

E 32916

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 7-9 Ward)2-FULL NAME Frederick J. Davis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. Eastern Ave & Sewer Road St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr 13/1928

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

Balto., Md.

10 NAME OF FATHER

Fred. J. Davis Sr

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Balto. Comm Md.

12 MAIDEN NAME OF MOTHER

Thelma Smith

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Balto. Md.

14

Informant ..... Father  
(Address) .....

15

16 1928 C. HAMPTON JONES, R. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 Apr 16/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Congenital Valvular Valvulus upper  
ileum. (Intestinal obstruction)

(Autopsy) (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)(Signed) J. H. Pate (duration) ..... yrs. .... mos. .... ds.  
(Coroner) M. D.

4/16/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Trinity Cemetery

4/17 1928

20 UNDERTAKER

George W Zickler

ADDRESS

1737 E Egl

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32917

## CERTIFICATE OF DEATH

16<sup>2</sup> E 32917

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *19-47* St., Ward)2-FULL NAME *Baby Boy Baum*(a) RESIDENCE NO. *719 E 36<sup>th</sup> St.*

(Usual place of abode)

St. Ward

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**white**Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*

6 DATE OF BIRTH (month, day, and year)

*4-13-28*

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or min..

*3*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Balto, Md.*

10 NAME OF FATHER

*A. S. Baum Jr.*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Balto, Md.*

12 MAIDEN NAME OF MOTHER

*Evelyn Keating*

13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

*Balto, Md.*

14

Informant (Address)

*Hospital records*

15 Filed

G. HARRISON JONES, Jr.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*4-16-28*

17

I HEREBY CERTIFY, That I attended deceased from

*4-13*19 *28*, to*4-16*19 *28*,

that I last saw him alive on

*4-16*19 *28*,

and that death occurred, on the date stated above, at

*8:00 A. m.*

The CAUSE OF DEATH\* was as follows:

*Haemorrhagic disease of the New born*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

*Pulmonary edema*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *NO* Date ofWas there an autopsy? *NO*What test confirmed diagnosis? *Clinical*

(Signed)

19

*Dr. J. H. Jones, Jr., M. D.*

\*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Burial in cemetery**April 17, 1928*

20 UNDERTAKER

ADDRESS

*W. M. Rounton**223 P.W.**with*

very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32918

## CERTIFICATE OF DEATH.

45 E 32918

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 E. 20th

## 2-FULL NAME

Katherine S. Cragg

(a) RESIDENCE No. 204 E. 20th  
(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 7 mos. 1

ST. WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1848

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
79 7 1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER Joseph Cragg

11 BIRTHPLACE OF FATHER (city or town) England  
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Loeffler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland14 Informant Mrs. John A. Hartman  
(Address) 612 University Parkway

15 File 61328 19 HANFSON JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1928

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to April 16, 1928, that I last saw him alive on April 15, 1928, and that death occurred, on the date stated above, at 6:35 a. m.

The CAUSE OF DEATH\* was as follows:

Intestinal Carcinoma

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Just Run

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Miller M. D.  
Apr 16 1928 (Address) 108 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Olivet Cemetery

DATE OF BURIAL

4/18 1928

20 UNDERTAKER

Henry U. Mears 2405 N. Calvert

HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH

E 32919

E 32919

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *810 Winston Ave* ST. *77-48* WARD)2—FULL NAME *Martha Ellen Gattan*(a) RESIDENCE NO. *810 Winston Ave* ST. *77-48* WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND or (or) WIFE of *James P. Gattan*6 DATE OF BIRTH (month, day, and year) *Nov. 4/1867*7 AGE Years *60* Months *5* Days *11* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *Walter Shamer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Mary Jane Crowe*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*14 Informant *James P. Gattan* (Address) *810 Winston Ave*

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 15/28*17 I HEREBY CERTIFY, That I attended deceased from *March 2*, 19*28*, to *April 15*, 19*28*, that I last saw her alive on *April 15*, 19*28*, and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH\* was as follows:

*Curvature of liver*CONTRIBUTORY (Secondary) *Tuberculosis* (duration) *1+* yrs. mos. ds.18 Where was disease contracted if not at place of death? (duration) yrs. mos. *2* ds.Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chest X-ray* (Signed) *S. V. Bishop*, M. D.1916, 1928 (Address) *501 Sheridan Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Greenmount Cemetery*  
*Mary M. Wadfield**April 17 1928*  
*501 E 22nd St*

16 1928 C. HAMPTON JONES

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32920

## CERTIFICATE OF DEATH.

119 E 32920

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sinai Hospital* ST. *2-4* WARD)2-FULL NAME *Wilhelmina Paul*(a) RESIDENCE NO. *408 S. Durham*

(Usual place of abode)

ST. *Balti.* WARD *und.*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *4* yrs. *1* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

*Female*

4-COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*James Paul*

6 DATE OF BIRTH (month, day, and year)

*April 29, 1857*

7 AGE

Years

Months

Days

If LESS than 1 day, his or min.

*56**11**16*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*John H. Hacker*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Marie Meyer*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*James Paul 408 S. Durham St.*

15

Filed *10-13-28* 19Registrar *OPK*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4/15 1928*

17

HEREBY CERTIFY, That I attended deceased from *4/12/28*, 19, to *4/15/28*, 19, that I last saw her alive on *4/15/28*, 19and that death occurred, on the date stated above, at *9:00 A.M.*

The CAUSE OF DEATH\* was as follows:

*Generalized Peritonitis - gangrene of intestine*(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

*Acute Cardiac Dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*S.H.*

Did an operation precede death?

*yes*

Date of

*4/12/28*

Was there an autopsy?

*yes*

What test confirmed diagnosis?

*Autopsy findings*

(Signed)

*B. J. Cohen*

M. D.

, 19

*Sinai Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*OAK LAWN CEMETERY**April 18, 1928*

20 UNDERTAKER

*HENRY Sander & Sons Inc*

ADDRESS

*Broadway & Baltimore St.*

E 32921

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32921

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *221 Poplar*ST. *Charles Bay*

REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Michael Himmel*(a) RESIDENCE NO. *221 Poplar*

(Usual place of abode)

ST. *Charles Bay*

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *53* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *white*5 Single, Married, Widowed, or Divorced, (write the word) *widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary Himmel*6 DATE OF BIRTH (month, day, and year) *aug 13, 1849*

7 AGE

Years *78*Months *8*Days *7*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *George Himmel*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14

Informant (Address) *Mary Himmel*

15

Filed *11/10/23*, 19 *23*Registrar *R. H. H.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4.15* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *8.1.* 19 *27* to *4.15.* 19 *28*that I last saw him alive on *4.15* 19 *28*and that death occurred, on the date stated above, at *7.30 A* m.

The CAUSE OF DEATH\* was as follows:

*Mitral Regurgitation*  
*Auricular Fibrillation*(duration) *don't know* yrs. mos. ds.CONTRIBUTORY (Secondary) *Myocardial Insufficiency*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Exam.*  
(Signed) *Edward Norris*, M. D.4-16-28 Address *107 East West St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER *Edward Hill*ADDRESS *107 East West St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32922

## CERTIFICATE OF DEATH.

101-001 E 32922

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *609 Clements*)ST. *24-33* WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Michael J. Finan*

## (a) RESIDENCE NO.

*609 Clements*

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Margaret Finan*

## 6 DATE OF BIRTH (month, day, and year)

*Aug. 9, 1868*

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs

or min.

*59**8**6**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Engineer.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Inter Ocean Oil Co.*

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

## 10 NAME OF FATHER

*Patrick Finan*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Ireland.*

## 12 MAIDEN NAME OF MOTHER

*Mary Gaffe*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ireland*

## 14

Informant  
(Address)*Margaret Finan  
609 Clements*

## 15

Filed

*1928* REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 14 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr. 9 1928*, to *Apr. 14 1928*.that I last saw him alive on *Apr. 13 1928*.and that death occurred, on the date stated above, at *130 A* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(duration) yrs. mos. *5* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. T. Seabury*, M. D.*4-16, 1928* (Address) *636 Fort Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

*Holy Cross Cem. &c.**April 17 1928*

## 20 UNDERTAKER

*Margaret H. Flynn*

## ADDRESS

*1422 Light*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32923

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 161 W. Hamburg ST., 22 WARD)2-FULL NAME Howard William Jackson(a) RESIDENCE NO. 161 W. Hamburg ST., 22 WARD(Usual place of abode)  
Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)REGISTERED NO. E 32923  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eula B. Jackson6 DATE OF BIRTH (month, day, and year) Jan 30, 18747 AGE Years 54 Months 2 Days 15 If LESS than 1 day, hrs. 14 or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md  
(State or country)10 NAME OF FATHER Geo. E. Jackson11 BIRTHPLACE OF FATHER (city or town) Md  
(State or country)12 MAIDEN NAME OF MOTHER Elizabeth Ross13 BIRTHPLACE OF MOTHER (city or town) Md  
(State or country)14 Informant James Jackson  
(Address) 161 W. Hamburg St.15 Filed PR 17 1928 HAWKINS Register

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17 192817 I HEREBY CERTIFY, That I attended deceased from 2/27, 1928, to 4/13, 1928, that I last saw him alive on 4/13, 1928, and that death occurred, on the date stated above, at 24 m.The CAUSE OF DEATH\* was as follows:  
Acute Myocarditis, Acute Dilatation, Pulmonary Hypostasis(duration) yrs. mos. ds. 5 ds.CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) yrs. mos. ds. 1 mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical History(Signed) W. C. Bishop, M. D., 19 (Address) 709 S. Sharp St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Auburn 4-17-28

20 UNDERTAKER

ADDRESS

John H. Toadner 1027Hand Hill

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32924

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 32924

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 520 S. Madeira Street St. 1-3 Ward)

2-FULL NAME Dorothy Napora

(a) RESIDENCE NO. 520 S. Madeira Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Infant

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)  
July 28/1927

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

8 18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER Ignacy Napora

11 BIRTHPLACE OF FATHER (city or town) Poland  
(State or country)

12 MAIDEN NAME OF MOTHER Rozalia Zochowska

13 BIRTHPLACE OF MOTHER (city or town) Poland  
(State or country)

14 Informant Ignacy Napora  
(Address) 520 S. Madeira Street

15 APR 17 1928  
For Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

numonia Emphysema  
(duration) yrs. mos. ds. 12

CONTRIBUTORY (secondary) Atherosclerosis  
(duration) yrs. mos. ds. 1  
(signed) J. O. Hadley M. D.  
(Coroner)

19 (Address) 143 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

ST. STANISLAUS, CEMETERY April 17, 1928

20 UNDERTAKER ADDRESS

George A. Weber, 2705 Bank

OF DEATH IN plain terms, so that it may be very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32925

## CERTIFICATE OF DEATH.

90 E 32925

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 570 W. Preston 17-24 Ward)

## 2-FULL NAME

Silvery Foote

## (a) RESIDENCE NO.

Luthville Md. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female Colored.

## 4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan. 31-1865

## 7 AGE

Years

Months

Days

IF LESS than

6321713

1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

St Mary County

## 10 NAME OF FATHER

Marion Robertson

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

St Mary County

## 12 MAIDEN NAME OF MOTHER

Marion Stewart

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

St Mary County

## 14

Informant (Address)

Mrs. Ethel Payne nee Spencer  
570 W. Preston St.

## 15 Filed

17 1928

K. M. C.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1928

## 17

I HEREBY CERTIFY That I attended deceased from April 1, 1928, to April 11, 1928,that I last saw him alive on April 11, 1928,and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease(duration) 1 yrs. 4 mos. ....ds.

## CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

## 18 Where was disease contracted

If not at place of death

Luthville, Md.Did an operation precede death? no Date of.....Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

E. J. Johnson, M. D.

, 19

(Address)

2529 S. Hampden

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Laurel Cemetery4/17 1928

## 20 UNDERTAKER

ADDRESS

Eugene Payne570 W. Preston St.OF DEATH IN PART TERMS, SEE INSTRUCTIONS ON BACK OF CERTIFICATES.  
very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32926

E 32926

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* *27-41* Ward)2-FULL NAME *Margaret Evans* (*Curran Ave*)(a) RESIDENCE NO. *4017 Endman Ave* St. *27-41* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. *11* mos. *12* ds. How long in U. S. if of foreign birth? *4* yrs. *11* mos. *12* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 4, 1923*7 AGE Years *4* Months *11* Days *12* IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School Girl*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) *BALTO MD*  
(State or country)10 NAME OF FATHER *George Evans*11 BIRTHPLACE OF FATHER (city or town) *BALTO MD*  
(State or country)12 MAIDEN NAME OF MOTHER *Lottie H. Gregory*13 BIRTHPLACE OF MOTHER (city or town) *BALTO MD*  
(State or country)14 Informant *Lottie H. Evans*  
(Address) *4017 Endman Ave*15 Filed *17 1928* Registrar *Kelly*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/16/28* 1917 I HEREBY CERTIFY, That I attended deceased from *4/9/28*, 19, to *4/16/28*, 19, that I last saw him alive on *4/16/28*, 19, and that death occurred, on the date stated above, at *12 m.*

The CAUSE OF DEATH\* was as follows:

*Septic meningitis*CONTRIBUTORY *Chronic B. Latere Mastoid*  
(Secondary) *ITIS*

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *4/9/28*

Was there an autopsy?

What test confirmed diagnosis? *Operation and clinical findings*  
(Signed) *Wm. S. Woodward, M. D.*  
19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8) Baltimore City Hospitals (T. 4-6 ST. WARD)

2-FULL NAME William Free

(a) RESIDENCE No. 45 Market Place

(Usual place of abode)

Length of residence in city or town where death occurred Unknown

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced, HUSBAND of or WIFE of Ella Free

6 DATE OF BIRTH (month, day, and year) Feb 19, 1861

7 AGE

Years 67

Months 1

Days 27

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D.C.  
(State or country)

10 NAME OF FATHER Wm. Free

11 BIRTHPLACE OF FATHER (city or town) Wash., D.C.  
(State or country)

12 MAIDEN NAME OF MOTHER Harriett Sibley

13 BIRTHPLACE OF MOTHER (city or town) Wash., D.C.  
(State or country)14 Informant Hospital Records  
(Address)

15 Filed 1928 H. JONES, R. J. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 19 28

17

I HEREBY CERTIFY, That I attended deceased from March 8, 19 28, to April 16, 19 28, and that I last saw him alive on April 16, 19 28, and that death occurred, on the date stated above, at 3.15 a. m.  
The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis Clinical & autopsy  
(Signed) J. M. Adder, M. D.

4-16-28 Address Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

April 18, 19 28

20 UNDERTAKER

ADDRESS

J. M. Cook

500 E. North Ave

E 32928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

167-001 ✓  
E 32928

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *769 Washington Blvd.* WARD)2-FULL NAME *Baby Boy Lewis*(a) RESIDENCE NO. *769 Washington Blvd.* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Milton Lewis*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md.*

12 MAIDEN NAME OF MOTHER

*Margaret Wright*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md.*

14

Informant (Address)

R 17 1928

G. HAMMOND JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 13 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 13 1928* to *April 13 1928* that I last saw him alive on *April 13 1928*and that death occurred, on the date stated above, at *12 50 p.m.*

The CAUSE OF DEATH\* was as follows:

*Prematurity  
Congenital Abnormalities*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Phys exam*(Signed) *Wright Reynolds* M. D.19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32929

## CERTIFICATE OF DEATH.

E 32929

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 430-8-12<sup>th</sup> St., 26 Ward)2-FULL NAME William Vogel Jr.(a) RESIDENCE NO. 430-8-12<sup>th</sup> St., 26 Ward(Usual place of abode)  
Length of residence in city or town where death occurred 7 weeks yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb. 25, 19287 AGE Years Months / Days 2 IF LESS than 1 day.....hrs. or.....min.  
7 weeks 1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)10 NAME OF FATHER Wm Vogel11 BIRTHPLACE OF FATHER (city or town) Balto. Md.  
(State or country)12 MAIDEN NAME OF MOTHER Helen Scheben13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Wm Vogel  
(Address) 430-8-12<sup>th</sup> St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928  
April 1617 I HEREBY CERTIFY, That I attended deceased from April 12, 1928, to April 15, 1928,  
that I last saw him alive on April 15, 1928,  
and that death occurred, on the date stated above, at 2:40 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia(duration) yrs. mos. ds. 3 ds.CONTRIBUTORY measles  
(Secondary)(duration) yrs. mos. ds. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.  
, 19 (Address) 4700 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mount Carmel Cemetery April 17 192820 UNDERTAKER Lilly & Zeiler Inc.  
ADDRESS 4008 North St.

OF DEATH IN PRINT TERMS, SO THAT IT MAY BE VERY IMPORTANT. See instructions on back of certificates.

APR 17 1928

C. H. JONES, JR.  
Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32930

## CERTIFICATE OF DEATH.

129 E 32930

## 1-PLACE OF DEATH

City of BALTIMORE (No. 1015 N. Lenoire St., 16-23 Ward)

## 2-FULL NAME

Bertha C. Ringgold

## (a) RESIDENCE NO.

1015 N. Lenoire St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40.

(If non-resident give city or town and State)  
mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

Cal.

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Geo. S. Ringgold

## 6 DATE OF BIRTH (month, day, and year)

Sept. 1, 1882

## 7 AGE

45 Years

Months

46

4

Days

14

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Boston, Mass.

(State or country)

## 10 NAME OF FATHER

Geo. Lowden

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Boston, Mass.

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Mass.

## 14

Informant

(Address)

Mrs. Bertha Bourie  
1015 W. Lenoire St.

## 15 Filed

1928

C. H. HARRIS

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14/1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar. 12, 1928, to April 14, 1928

that I last saw her alive on April 13, 1928

and that death occurred, on the date stated above, at 7:45 a. m.

The CAUSE OF DEATH\* was as follows:

Uremia

(duration) yrs. mos. ds.

## CONTRIBUTORY

Chronic Intestinal  
(Secondary) Nephritis several months

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) H. H. Jones, M. D.

19 (Address) 1012 N. Lafayette St.

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Calvary Cem 4/17/28

## 20 UNDERTAKER

ADDRESS

Samuel H. Hensley &amp; Co. 75

OF DEATH IN plain terms, so that it may be easily understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32931

98 E 32931

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1141 Park St. 11-24 Ward)2-FULL NAME Henrietta F. Goodood(a) RESIDENCE NO. 1141 Park St. Ward 11-24

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Cool 5 Single, Married, Widowed, or Divorced, (write the word) Widow6a If married, widowed, or divorced, HUSBAND of (or) WIFE of Thos H Toogood6 DATE OF BIRTH (month, day, and year) Jan 1-18377 AGE Years 91 Months 3 Days 12 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind (State or country)10 NAME OF FATHER Harry Bulley11 BIRTHPLACE OF FATHER (city or town) Ind (State or country)12 MAIDEN NAME OF MOTHER Jane Mitchell13 BIRTHPLACE OF MOTHER (city or town) Ind (State or country)14 Informant Sarah H. Toogood (Address) 1141 Park St.15 Filed 1928 C. HARRIS, Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis (duration) 7 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) 7 yrs. mos. ds. (Address) North Ave & Dimm

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurie Cem Date of Burial 4/17/2820 COFFINER Samuel Hensley ADDRESS 78

OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

E 32932

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 1/2 Belvidere Ave. 6-10 WARD)2-FULL NAME Edward C. Schneider(a) RESIDENCE NO. 407 1/2 Belvidere

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds.ST. 6 WARD 10REGISTERED NO. E 32932

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorisella Schneider6 DATE OF BIRTH (month, day, and year) Sept 18, 1885

7 AGE

Years 42Months 5Days 27

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Chas Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary E. Linpert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mr Dorisella Schneider  
407 1/2 Belvidere Ave.

15

Filed

PR 17 1928

HARVEY JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 24, 1928, to April 13, 1928, that I last saw him alive on April 13, 1928, and that death occurred, on the date stated above, at 2-20 m. The CAUSE OF DEATH\* was as follows:Stenocardia, from carcinoma of bladder,(duration) yrs. mos. 3 ds.CONTRIBUTORY (Secondary) Carcinoma of urinary bladder;(duration) yrs. mos. 6 mos. 14 ds.18 Where was disease contracted if not at place of death? Intestine Heights, Md.Did an operation precede death? yes Date of Jan 27-28Was there an autopsy? NoWhat test confirmed diagnosis? Microscopic exam of spec  
(Signed) A. D. Hutchins M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Gordon Park Cem

20 UNDERTAKER

John Lelrick

DATE OF BURIAL

Apr 19 1928

ADDRESS

2007 Belvidere

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32933

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 32933

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 Walbrook Ave.

WARD)

2-FULL NAME John H. Maxfield

(a) RESIDENCE No. 1902 Walbrook Ave.  
(Usual place of abode) Lifetime

ST. WARD

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

Widower

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Georgianna Maxfield

6 DATE OF BIRTH (month, day, and year) Sept. 25th, 1854

7 AGE Years Months Days If LESS than  
1 day, hrs.  
or min.

73

11

22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Retired(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Maryland

10 NAME OF FATHER John W. Maxfield

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Mummie

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Maryland14 Informant Mrs. Edward H. Thomas  
(Address) 1627 E. North Ave.

15 Filed 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th, '28.

17

HEREBY CERTIFY, That I attended deceased from

April 5th, 1928, to April 16th, 1928  
that I last saw him alive on April 15th, 1928

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH\* was as follows:

Acute Cordial Distention

CONTRIBUTORY (Secondary) Myocarditis  
(duration) yrs. mos. ds.  
(duration) yrs. 18 mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. W. Montgomery M. D.

4/14/28 (Address) 401 E 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Waugh Chapel

DATE OF BURIAL

4/19/28

20 UNDERTAKER

ADDRESS

Geo. P. Evans &amp; Son 118 W. Mt. Royal Ave.



# **E 32934 HEALTH DEPARTMENT—CITY OF BALTIMORE**

## **CERTIFICATE OF DEATH.**

### **1-PLACE OF DEATH**

CITY OF BALTIMORE: (No. 709 Roland Ave. Roland Park St.

**2-FULL NAME** John J. Moylan.

(a) RESIDENCE NO. 709 Roland Ave. Roland Park, ST, WARD  
(Usual place of abode) Lifetime.

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### **PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX**

Male

**4 COLOR OR RACE**

White

**5 Single, Married, Widowed, or Divorced, (write the word)**

Married

**5a If married, widowed, or divorced**  
HUSBAND of  
(or) WIFE of

Mary D. Moylan

**6 DATE OF BIRTH** (month, day, and year)

**7 AGE**

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

65

9

18

**8 OCCUPATION OF DECEASED**

(a) Trade, profession or particular kind of work

Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9 BIRTHPLACE** (city or town)  
(State or country)

Balto. Md.

**10 NAME OF FATHER** John Moylan

**11 BIRTHPLACE OF FATHER** (city or town)  
(State or country)

Ireland

**12 MAIDEN NAME OF MOTHER** Ann McDonald

**13 BIRTHPLACE OF MOTHER** (city or town)  
(State or country)

Ireland

**14 Informant** Mrs Mary D. Moylan  
(Address)

709 Roland Ave. Roland Park.

**15 Filed** 7 1928

27-53

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### **MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** (month, day, and year) April 15th, 28

**17**

I HEREBY CERTIFY that I attended deceased from Jan 1st, 1927, April 15, 28 that I last saw him alive on April 15, 28 and that death occurred, on the date stated above, at 1.45 P. M. The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

**CONTRIBUTORY**  
(Secondary)

(duration) 2 yrs. + mos. ds. Pulmonary Haemorrhage

**18 Where was disease contracted**  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Those of Nephritis  
(Signed) Walter C. Bacon, M. D.

(Address) 100 E 22  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

**19 PLACE OF BURIAL, CREMATION OR RE-MOVAL**

Cathedral Cemetery.

**DATE OF BURIAL**

4/18 1928

**ADDRESS**

**20 UNDERTAKER**

Chas. P. Grandison 118 Mt Royal Ave

E 32935

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32935

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2515 Salem St.

ST. 13-59 WARD)

2. FULL NAME Alvin D. Ward

(a) RESIDENCE NO. 2515 Salem St.

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 21 mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9th, 1926

7 AGE Years 1 Months 21 Days 7 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Allen D. Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co. Md.

12 MAIDEN NAME OF MOTHER Elsie G. Bomolitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co. Va.

14 Informant (Address) Allen D. Ward 2515 Salem St.

15 Filed APR 17 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1928

17 I HEREBY CERTIFY, That I attended deceased from March 19th, 1928, to April 16th, 1928, that I last saw him alive on April 16th, 1928, and that death occurred, on the date stated above, at 7:10 P.m.

The CAUSE OF DEATH\* was as follows:

Measles 10 Day Pneumonia (bronchial)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Revolutian, M. D.

4/17, 1928 (Address) 24 X Fulton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREATION OR RE-NOVA

Lancaster Co. Va.

20 UNDERTAKER

Robert Brooks Olson

DATE OF BURIAL

4/17 1928

ADDRESS

Calhoun Hollins

E 32936

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32936

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Sinai Hospital

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST. \_\_\_\_\_

2-FULL NAME

Benj. Masserovitz

(a) RESIDENCE NO.

1003 N. Bond St.

(Usual place of abode)

ST. \_\_\_\_\_

Length of residence in city or town where death occurred

38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Bertha Masserovitz

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

67

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoe Repairing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Leib -

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Fajis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Bertha Masserovitz  
1003 N. Bond St.

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/17

1928

17

I HEREBY CERTIFY, That I attended deceased from

4/16

1928, to

4/17

1928,

that I last saw him alive on

4/17

1928

and that death occurred, on the date stated above, at 12.43 a.m.

The CAUSE OF DEATH\* was as follows:

Chr. nephritis

Chr. myocarditis

red. failure

(duration) ?

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Examination

(Signed)

Meyer Miller

M. D.

4/17, 1928 (Address)

Sinai Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Gledale

4/17/28

20 UNDERTAKER

Jack Lewis

ADDRESS

1439 E. Baltimore

TION is very important See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32937

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sinai Hospital*)ST. *15-22* WARD)2. FULL NAME *Max Feinstein*(a) RESIDENCE No. *1340 N. Fulton*  
(Usual place of abode)Length of residence in city or town where death occurred *37* yrs. mos.

ST. WARD

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? *37* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of *Sophia Feinstein*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *1928*7 AGE Years *55* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Sailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*14 Informant *Sophia Feinstein*  
(Address) *1340 N. Fulton Ave*15 Filed *1928* REGISTRAR *R. H. Jones, H. E. Jones*

Registrar

E 32937

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-16* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *4-11*, 19 *28*, to *4-16*, 19 *28*.that I last saw him alive on *4-16*, 19 *28*and that death occurred, on the date stated above, at *3 20 P* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Failure**Broncho-Pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY *Septic Thrombo-Phlebitis of Rt. Arm*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *4-14-28*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Harry Weintraub*, M. D., 19 (Address) *Sinai Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Hebron Rosedale**4/17* 19 *28*

UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Baltimore*



# Ravlin

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32938

## CERTIFICATE OF DEATH.

31 E 32938

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 231 N. Poppleton St. 18-76 Ward)

Registered No. ....

2-FULL NAME... William Thomas Ravlin

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 231 N. Poppleton St. .... Ward ....  
(Usual place of abode)Length of residence in city or town where death occurred 34 yrs. .... mos. .... ds. How long in U. S. if of foreign birth? yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, m 4-COLOR OR RACE, C. 5-Single, Married, Married or Divorced, (Write the word.)5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Ravlin6-DATE OF BIRTH (month, day and year) May 2, 18887-AGE, 40 yrs. 11 mos. 12 ds. If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Lab. 40  
(b) General nature of industry, business, or establishment in which employed (or employer)... Merch - work  
(c) Name of employer.....9-BIRTHPLACE (city or town)... Catonville, Ind.  
(State or Country),10-NAME OF FATHER, unknown11-BIRTHPLACE OF FATHER (city or town)... unknown  
(State or Country),12-MAIDEN NAME OF MOTHER, Elsie (unknown)13-BIRTHPLACE OF MOTHER (city or town)... unknown  
(State or Country),14- (Informant)... Annie Ravlin  
(Address)... 231 N. Poppleton St.15- PR 17 1928 C. HARRY JONES, M.  
Filed 17 1928 RAH Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 14, 192817- I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1928 to April 14, 1928that I last saw him alive on April 13, 1928and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Phthisis(Duration) .... yrs. 6 mos. 11 ds.CONTRIBUTORY Pulmonary Arteriosclerosis  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted  
If not at place of death? .....Did an operation precede death? no Date of .....Was there an autopsy? noWhat test confirmed diagnosis? Sputum(Signed) H. Maceo Williams, M. D.4-16-1928 (Address) 830 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St. Auburn Cemetery DATE OF BURIAL, April 17, 192820-UNDERTAKER, Mrs. Kate R. Williams ADDRESS 322

Instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32939

## CERTIFICATE OF DEATH.

113 E 32939  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, No. 9th Bmbrg-25-75 ST. WARD)

## 2-FULL NAME Rose Ellen Gleason

(a) RESIDENCE No. 9th Bmbrg

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

yrs. Life mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2-1927

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 4 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)

10 NAME OF FATHER James H. Gleason

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Carrie Shneyer

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant James H. Gleason (Address) 9th Bmbrg, Balto. Md.

15 Filed 17 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15 1928

17 I HEREBY CERTIFY, That I attended deceased from 4/7-1928 to 4/15-1928 that I last saw him alive on 4/15-1928

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH\* was as follows:

Ectro-Calitus

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chucup

(Signed) M. D.

, 19 (Address) 1340 S. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH is very important. See instructions on back of certificates.

PR 17 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32940

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *624 N. Carey St* ST. *16-23* WARD)2-FULL NAME *Leroy Pinkard*(a) RESIDENCE NO. *624 N. Carey*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs. *1* mos.

ds. Now long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *m*4 COLOR OR RACE *C.*5 Single, Married, Widowed, *Single*

or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of  
or WIFE of *Daisy Matthews*

6 DATE OF BIRTH (month, day, and year)

7 AGE *29* years*day*

Months

*March 18 1928*

If LESS than

day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Baby*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *VA*10 NAME OF FATHER *William Pinkard*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *VA*12 MAIDEN NAME OF MOTHER *Daisy Matthews*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *MD*

14

Informant  
(Address) *Daisy Matthews*  
*624 N. Carey St*

15

Filed *April 19 1928**1928**1928**1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 16 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*April 9 1928* to *April 16 1928*that I last saw him live on *April 16 1928*and that death occurred, on the date stated above, at *6.30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*

(duration)

yrs.

mos. *7*

ds.

CONTRIBUTORY  
(Secondary) *Broncho Pneumonia*

(duration)

yrs.

mos. *7*

ds.

18 Where was disease contracted

If not at place of death? *no*Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *A. G. W. Kennard*

M. D.

417 1928 (Address) *708 E. Union St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Solley Adams**April 17 1928*

20 UNDERTAKER

ADDRESS

*Adolphus Halstead**698 Pierce St*

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32941

## CERTIFICATE OF DEATH.

129 E 32941

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
4-10-1928, to 4-16-1928,that I last saw him live on 4-16-1928  
and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis - uremia -  
Hypertension.

(duration) unknown ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Henry Van cent Davis, M. D.

4/16, 1928 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL  
Oaklawn Cemetery

4/19 1928

UNDERTAKER

ADDRESS

William Cook

502 E. 11th

TION is very important. See instructions on back of certificates.

PR 17 1928

C. HAYDEN JONES, Jr.  
Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

32942

E 32942

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *man 100 Grant St. N. 5-8* Ward)2-FULL NAME *Isaac Garson*(a) RESIDENCE NO. *100 Grant St. N.*

St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 Color or Race

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*?*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

*About 5-0*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 1. 28* 19217 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.)and that said deceased came to *death* (Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Alcoholism*

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) *W. J. Rees* M. D.

(Coroner)

1928 (Address) *1237 Roman*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place *Grant St. N.* In the of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*Holy Cross A.C. Co 4-17 1928*

20 UNDERTAKER

ADDRESS

*W.B. Harker 1158 West St*

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation very important. See instructions on back of certificate.

PR 17 1928

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32943

## CERTIFICATE OF DEATH.

31

E 32943

1. PLACE OF DEATH *Leva Hospital*CITY OF BALTIMORE: (No. *26-37* ST. *WARD*)2. FULL NAME *John Kipp*(a) RESIDENCE NO. *3510 O'Donnell*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *mal*4 COLOR OR RACE *whit*5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Mary E. Kipp*6 DATE OF BIRTH (month, day, and year) *June 17-1868*7 AGE *59*

Years

Months *9*Days *29*If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Sanitary*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *Baltimore, Md.*10 NAME OF FATHER *John F. Kipp*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Annie Canoles*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Germany*

14

Informant *Chas F. Kipp*(Address) *3510 O'Donnell St*

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-16 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*4-11*, 19 *28*, to *4-16*, 19 *28*.that I last saw him alive on *4-16*, 19 *28*.and that death occurred, on the date stated above, at *11 P* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary tuberculosis*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

*Renal hyperkalemia of probable and cystitis*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *J. H. H. H.*

M. D.

, 19

(Address) *Leva Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *London Park Cemetery*DATE OF BURIAL *April 20 1928*20 UNDERTAKER *George W. Zickler*ADDRESS *1737 E. Eager*

TION is very important See instructions on back of certificates.

APR 17 1928

HARRISON

REGISTER

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32944

## CERTIFICATE OF DEATH.

101-2001

E 32944

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 N. Gilman St. 15 Ward)2-FULL NAME Ester Croffles(a) RESIDENCE NO. 1412 N. Gilman St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of Martin Nobler (or) WIFE of6 DATE OF BIRTH (month, day, and year) June 23 18817 AGE Years 46 Months 9 Days 22 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N.B. (State or country)10 NAME OF FATHER Anderson Nobler11 BIRTHPLACE OF FATHER (city or town) N.B. (State or country)12 MAIDEN NAME OF MOTHER Fannie Davis13 BIRTHPLACE OF MOTHER (city or town) N.Y.C. (State or country)14 Informant Bertice Nobler (Address) 1412 N. Gilman

15 Filed \_\_\_\_\_ 19 \_\_\_\_\_ Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said \_\_\_\_\_ (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signature) T. C. Smith M. D. (Address) North Ave & Union

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Link Hill N.C. 5/17 192820 UNDERTAKER Samuel Easton ADDRESS 716 Park

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

E 32945

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32945

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Carlton ST. 16-23 WARD)2-FULL NAME John Miller(a) RESIDENCE NO. 1014 Carlton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

Carrie Miller

6 DATE OF BIRTH (month, day, and year)

June 1894

7 AGE

Years

Months

Days

3310

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

South Carolina

10 NAME OF FATHER

Jerry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

South Carolina

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

South Carolina

14

Informant (Address)

Carrie Miller  
1014 Carlton St

APR 17 1928

HARRISON JONES, JR.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 11 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 7, 1928, to Apr 11, 1928, that I last saw him alive on Apr 11, 1928, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.4/11/28 Address) 1928 Pa Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Mrs. Bee S. C.

UNDERTAKER

Deane E. E. E.

ADDRESS

916 Pa Ave



E 32946

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, NO.

2-FULL NAME

(a) RESIDENCE NO.

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced. (write the word)5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town,  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15

Filed

ST.

WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

WARD

(If non-resident give city or town and State)  
yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
10-3-1927, to 4-14-1928  
that I last saw him alive on 4-13-1928  
and that death occurred, on the date stated above, at 5:30 A. M.  
THE CAUSE OF DEATH\* was as follows:Terminal Broncho Pneumonia  
Cerebral ThrombosisCONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address

\*State the Disease Causing Death, or in deaths from violent causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

TION is very important See instructions on back of certificates.

APR 17 1928

REGISTER

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32947

38 E 32947

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1441 Ward St 21-28 Ward)2-FULL NAME William E. Effek(a) RESIDENCE NO. 1441 St. Ward St Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 Color or Race Caucasian5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18757 AGE 53

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Librarian

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Baltimore10 NAME OF FATHER John E. Moore

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

## 14

Informant (Address) 1441 W. Ward St

## 15 Filed

19

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said Inquestfind that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

(Signature) John B. Horton M. D. (Coroner)1928 Address Curtis Bay\*State the Disease Causing Death, or death from Heart Causes, state (1) Means and Nature of Injury and (2) Cause of Injury, Accidental, Suicidal, or Homicidal. (See reverse side of this certificate.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 7/17-1928

## 20 UNDERTAKER

ADDRESS 62 ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32948

## CERTIFICATE OF DEATH.

E 32948

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 Numcen ST. 17-24 WARD)2-FULL NAME Cora Carrie White(a) RESIDENCE NO. 537 Numcen ST. 17-24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? 4 yrs. 1 mos. 10 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of [Signature]6 DATE OF BIRTH (month, day, and year) Sept 16 19117 AGE Years 16 Months 7 Days 29 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic(b) General nature of industry, business, or establishment in which employed (or employer) o/o

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md10 NAME OF FATHER Daniel White11 BIRTHPLACE OF FATHER (city or town) Dover (State or country) N. H.12 MAIDEN NAME OF MOTHER Mary Cooper13 BIRTHPLACE OF MOTHER (city or town) Annapolis (State or country) md14 Informant Daniel White (Address) 537 Numcen15 Filed 19 Registrar [Signature]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 15 192817 I HEREBY CERTIFY, That I attended deceased from Apr 8, 19 28, to Apr 15, 19 28, that I last saw her alive on Apr 14, 19 28 and that death occurred, on the date stated above, at 5:20 A m.

The CAUSE OF DEATH\* was as follows:

Bilateral Lobar PneumoniaCONTRIBUTORY (Secondary) Acute Bronchitis (duration) 10 yrs. 10 mos. 10 ds.(duration) 1 yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) [Signature] M. D.Address 1126 Grand Ave

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

MOV. W. Allen Lane 4/17 192820 UNDERTAKER [Signature] ADDRESS 916Ca. ave

CAUSE OF DEATH IN PLAIN TERMS, SO THAT THE REASON FOR THE DEATH IS UNDERSTOOD BY ALL PERSONS CONCERNED. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32949

32949

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1409 Hanover St. 23-31 Ward)

Registered No. ....

2-FULL NAME. Emma E. Reinhardt

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1409 Hanover St. .... Ward. ....

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 7 mos. 17 ds. How long in U. S. if of foreign birth? yrs. .... mos. .... ds. ....

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Louis F. Reinhardt

6-DATE OF BIRTH (month, day and year) Sept 1 1861

7-AGE 66 yrs. 7 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. House Work (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balt Md

PARENTS. 10-NAME OF FATHER, Chas Harrison 11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md 12-MAIDEN NAME OF MOTHER, Berrianna Reis 13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt Md

14- (Informant) Louis F. Reinhardt (Address) 1409 Hanover St

15- Filled J. HARRISON JONES, M. D. Registrar. R.R.K.

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH (month, day and year) April 16 1928

I HEREBY CERTIFY, That I attended deceased from Mar 20 1928 to April 16 1928

that I last saw him alive on April 14 1928 and that death occurred, on the date stated above, at 3:20 A.M.

The CAUSE OF DEATH was as follows: Severe myocarditis

CONTRIBUTORY (Secondary) (Duration) yrs. .... mos. .... ds. 10

18-Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microsc

(Signed) J. HARRISON JONES, M. D. 416 1928 (Address) 416

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL, April 19 1928

20-UNDERTAKER, E. Schloman &amp; Son ADDRESS 1034

in plain terms, so that it may be properly instructions on back of certificates.

R 17 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32950

## CERTIFICATE OF DEATH.

198 E 32950  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)2-FULL NAME Arthur Commodore.(C)(a) RESIDENCE NO. 880 W. Lexington St. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 Color or Race Colord 5 Single, Married, Widowed, or Divorced, (write the word) Married.5a If married, ~~XXXXXXXXXX~~ HUSBAND of Mattie Commodore.(C)  
(~~XXXXXX~~)6 DATE OF BIRTH (month, day, and year) September 13, 18917 AGE Years 36 Months 7 Days 2 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore.

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

## 9 BIRTHPLACE (city or town)

(State or country) Calvert Co. Md.10 NAME OF FATHER William Commodore.(C)11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Calvert Co. Md.12 MAIDEN NAME OF MOTHER Suddie Boome.(C)13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) Calvert Co. Md.14 Informant Mattie Commodore.(C) wife.  
(Address) 880 W. Lexington St.15 Filed C. H. HANCOCK JOHNS Registrar  
Per \_\_\_\_\_

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said autopsy & inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Fracture of the skull & hemorrhage  
Abscess of brain, right frontal lobe.  
Struck on the head by an axe.  
Homicide.(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Otto J. P. Essman M. D.  
(Coroner)4/17, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? Port Covington. April 7, 1928

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baker's Creek, Calvert Co., Md. 4/18 1928

## 20 UNDERTAKER

ADDRESS

John M. Toudrin 1027 Druid Hill Ave.

This should be carefully supplied. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

E 32951

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32951

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Bunch(a) RESIDENCE NO. 836 Maryland ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) ?5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 75

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman(b) General nature of industry, business, or establishment in which employed (or employer) 62

(c) Name of employer

9 BIRTHPLACE (city or town) Calto  
(State or country) Ind.10 NAME OF FATHER James Bunch11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Maribel Priest13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania  
(State or country)

14

Informant (Address) Records

15

Filed

17 1928

19

JAMESON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15/1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 9, 1928, to Apr. 10, 1928that I last saw him live on Apr. 10, 1928and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic + acute  
arteriosclerosis  
Hypertension(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General + Sub(Signed) C. William Bunch, M. D.  
, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore CemeteryApr 18 1928

20 UNDERTAKER

ADDRESS

John F. Denny715 Light St

TION is very important See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32952

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 E. Lombard

ST. 14-28 WARD)

2. FULL NAME Stanley Czekaewski

(a) RESIDENCE No. 1741 E. Lombard

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-15-28

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.  
(State or country)

10 NAME OF FATHER Boleslaw Czekaewski

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Poland

12 MAIDEN NAME OF MOTHER Agdalene Gonszo-

rowska  
13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Poland

14

Informant Boleslaw Czekaewski  
(Address) 1741 E. Lombard St

15

C. HAMPTON JONES, M. D.

7 1928

Per 19

2366

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-28 19

17

I HEREBY CERTIFY, That I attended deceased from

4-15-28, 19, to 4-15-28, 19,

that I last saw him alive on 4-15-28, 19,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH\* was as follows:

Atelectasis Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY\* rank breech presentation  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. E. Bronushas, M. D.

4-16-28 Address) 3037 O'Donnell St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health

16 1928

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32953

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Sinai Hospital

CITY OF BALTIMORE: (No.

2-FULL NAME

Louis Kalen

(a) RESIDENCE NO. 4353 Reisterstown  
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

M

5 Single, Married, Widowed,  
or Divorced (write the word)

S

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 30 1927

7 AGE

Years

Months

Days

9

17

18

If LESS than  
1 day, hrs.  
or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town,  
(State or country)

Baltimore, Md.

10 NAME OF FATHER

Bernard Kalen

11 BIRTHPLACE OF FATHER (city or town,  
(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Rena Garden

13 BIRTHPLACE OF MOTHER (city or town,  
(State or country)

Baltimore, Md.

14

Informant  
(Address)Bernard Kalen  
4553 Reisterstown Rd.

15

Filed

C. HAMPTON JONES, M. D.

Registrar

R 17 1928

REGISTERED NO.

E 32953

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

ST.

WARD

ST.

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/17 1928

17

I HEREBY CERTIFY, That I attended deceased from  
4/16 1928, to 4/17 1928.that I last saw him alive on 4/17 1928  
and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH\* was as follows:

Brachio. Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

4353 Reisterstown Rd.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Weintraub M. D.

, 19 (Address) Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Hebrew Rosedale

4/18 1928

20 UNDERTAKER

ADDRESS

Isch Lewis 1439 E. Baltimore



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32954

E 32954

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH *University Hospital*CITY OF BALTIMORE: (No. *Lombard + Greene* ST. *4-30* WARD)2. FULL NAME *Arthur V. Foard*(a) RESIDENCE NO. *Maple Ave., Catonsville* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — / ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of *Mat Foard* (or) WIFE of *May H. Spear*6 DATE OF BIRTH (month, day, and year) *April 4, 1883*7 AGE Years *45* Months *0* Days *12* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Civil Engineer*(b) General nature of industry, business, or establishment in which employed (or employee): *030*(c) Name of employer *Gibson Island Co*9 BIRTHPLACE (city or town) *Harford County* (State or country) *Maryland*10 NAME OF FATHER *Norval E. Foard*11 BIRTHPLACE OF FATHER (city or town) *Alexandria* (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Emily J. Virdin*13 BIRTHPLACE OF MOTHER (city or town) *North Carolina* (State or country)14 Informant *Hospital Record* (Address)

C. HANSON JONES, M. D.

1928 *12* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 16 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 16*, 1928, to *April 16*, 1928, that I last saw him alive on *April 16*, 1928, and that death occurred, on the date stated above, at *7:55 P. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*(duration) yrs. *8* mos. ds.CONTRIBUTORY (Secondary) *Uremia Coma*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *H. R. Schneider*, M. D.4/16, 1928 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Druid Ridge Cemetery**4/19, 1928*

UNDERTAKER

ADDRESS

*Henry W. Mears 805 N. Calvert*

CAUSE OF DEATH IN plain terms, so that it may be understood by laymen. See instructions on back of certificates.

E 32955

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32955

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 S Hilton St

2. FULL NAME Gordon F Bosse

(a) RESIDENCE No. 29 S Hilton St

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident, give city or town and State)  
ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 3/7/1904

7 AGE Years 24 Months 1 Days 9 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

10 NAME OF FATHER Frances Bosse

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Alice White

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14

Informant Mrs Alice Bosse (Address) 29 S Hilton St

15

17 1928

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 11, 1928, to Apr 26, 1928, that I last saw him alive on April 16, 1928, and that death occurred, on the date stated above, at 7 P m

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

Cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? El. O. Phy

(Signed) Fred T. Kypch M. D.

19 (Address) 3321 Frederick Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

1 MOVAL

20 UNDERTAKER

ADDRESS

Holy Redeemer Cemetery 4/19/28  
Albert L. Hiltz Jr 1606 N. Chester St

CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32956

## CERTIFICATE OF DEATH

129 E 32956

## 1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 2460 Greenmount St WARD)2—FULL NAME James Joseph Coughlin(a) RESIDENCE NO. 2460 Greenmount St WARD

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Mary A. Kearney (or WIFE of)6 DATE OF BIRTH (month, day, and year) Aug 11-18707 AGE 57 Years Months 5 Days 8 If LESS than 1 day, hrs. or min. 4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) County Galway Ireland (State or country)10 NAME OF FATHER James Coughlin11 BIRTHPLACE OF FATHER (city or town) County Galway Ireland (State or country)12 MAIDEN NAME OF MOTHER Catherine Cuddy13 BIRTHPLACE OF MOTHER (city or town) County Galway Ireland (State or country)14 Informant Nathaniel Coughlin (Address) 2460 Greenmount Ave15 Filed G. HANSON JONES, Jr. 19 11 1928 Registrar AKH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15-192817 I HEREBY CERTIFY, That I attended deceased from May 2, 1926, to April 15, 1928, that I last saw him alive on April 15-1928 and that death occurred, on the date stated above, at 12:15 P.m.

The CAUSE OF DEATH\* was as follows:

Uraemia Uraemia Crura  
3 daysCONTRIBUTORY (Secondary) Intestinal Neoplasm (duration) yrs. mos. 3 ds.(duration) 2 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Colonic(Signed) J. J. Anderson M. D.April 17, 1928 (Address) 219 E. Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery April 18 1928

20 UNDERTAKER

ADDRESS

Mary M. Wiedefeld 501 E. 32nd St

important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32957

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1114 Haubert St. St. 24-35 Ward)2-FULL NAME James Stifineski or Stanisley Stefanski.(a) RESIDENCE NO. 1114 Haubert St. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. \_\_\_\_\_ How long in U. S., if of foreign birth? 20 yrs. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Do not know.7 AGE Years 44 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore.

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

## 9 BIRTHPLACE (city or town)

(State or country) Poland.10 NAME OF FATHER Do not know.11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.12 MAIDEN NAME OF MOTHER Do not know.13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.14 Informant Catherine Polunski. (Address) 1114 Haubert St.15 Filed C. HAMFSON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cobar pneumonia.

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D. (Coroner)

4/17 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross Brooklyn April 18, 1928

20 UNDERTAKER ADDRESS

John M. Weber 401 S. Chester St.

tion should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

17 1928



E 32958

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Fleet

2-FULL NAME Mary Markowski

(a) RESIDENCE NO. 1917 Fleet

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos.

ST. 2-4 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1872

7 AGE Years 55 Months 10 Days 56 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housewife

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant Paul Markowski

(Address) 1917 Fleet St.

15

Filed 1920 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 19 28

17 I HEREBY CERTIFY, That I attended deceased from 3-25 1928 to 4-16 1928 that I last saw her alive on 4-15 1928 and that death occurred, on the date stated above, at 10:45 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach

CONTRIBUTORY (Secondary) Toxic absorption (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cook M. D.

4/17/28 (Address) 4137 Washington St. \*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

St. Stanislaus Cem April 19 28

20 UNDERTAKER

John M. Weber 4014 Chester St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32959

## CERTIFICATE OF DEATH.

90 E 32959

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 S Washington ST. 2-4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Kurek

(a) RESIDENCE NO. 226 S Washington ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 60

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER Joseph Stasiak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wiktorga Zmudziewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Kurek Son

(Address) 226 S Washington St.

15 Filed 1928 G. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 19 28

17

I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1928, to Apr. 17, 1928, that I last saw her alive on Apr. 15, 1928, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilatation  
Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia  
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed)

Geo. D. Lippert M. D.

(Address) 432 S. Patterson Pl. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

MOVING

Holy Rosary Cem April 21 1928

20 UNDERTAKER

ADDRESS

John W. Ueber 4014 Chester

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32960

## CERTIFICATE OF DEATH.

90 E 32960

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2601 N. Charles St. 12-50 Ward)2-FULL NAME Thomas Donahue(a) RESIDENCE NO. 2601 N. Charles St. 12-50 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? 72 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frances Hines6 DATE OF BIRTH (month, day, and year) March 16, 18327 AGE Years 96 Months 1 Days 0 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland  
(State or country)10 NAME OF FATHER James Donahue11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)12 MAIDEN NAME OF MOTHER Mary13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)14 Informant Miss Agnes Donahue  
(Address) 2601 N. Charles St.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Calculus Disease of Heart  
(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) J. H. Mearns M. D.(Address) 3632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery Date of Burial 4/18 192820 UNDERTAKER Henry W. Mearns ADDRESS 805 N. Calvert

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 17 1928

C. HANSON, JONES, M. Registrar

E 32961

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1537 N. Guilmore St. 15-21 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

Dec 22-1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Robert Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Ann Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Ann Wright 1537 N. Guilmore St.

15

Filed

17 1928

19

R. P. Jones, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/16 1928

17

HEREBY CERTIFY, That I attended deceased from 4/1, 1928, to 4/16, 1928, that I last saw him alive on 4/16, 1928,

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

A. G. Fardous

M. D.

4/17 1928 (Address)

918 E. Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St. Peter's

4/18 28

916 E. Fayette

Information should be carefully supplied. AGE should be given in years, months, and days. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 17 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32962

## CERTIFICATE OF DEATH.

31 E 32962

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11-24 ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Fleming(a) RESIDENCE NO. 9270 Lind Tree Lane

(Usual place of abode)

WARD

Length of residence in city or town where death occurred ? yrs. mos. ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

Lucy B. Fleming6 DATE OF BIRTH (month, day, and year) 7/18/88

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Marshall B. Fleming11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Julia Stidham13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14

Informant (Address) Records

15

File 17-1928

19

Registrar David Carter

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/1928

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1928 to Apr. 17, 1928.that I last saw him live on Apr. 17, 1928and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis  
tuberculosis meningitis  
effusion(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? General & Sub(Signed) C. J. Williams, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Princess Anne Md  
UNDERTAKER David Carter4/18/28  
ADDRESS 916  
Be ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32963

E 32963

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

Colonial Hosp

REGISTERED NO.

City of BALTIMORE: (No. 1122 N. Mount St. 14<sup>th</sup> Ward)

## 2-FULL NAME

Serg. Walter P. Boughman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1603 Linden Ave. St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Elsie Boughman

## 6 DATE OF BIRTH (month, day, and year)

November 11, 1901

## 7 AGE

Years

Months

Days

IF LESS than

1 day hrs.

or min.

26 yrs.

5

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

U.S. Army

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Penn.

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

## 14

Informant  
(Address)

Hospital Record

## 15 Filed

G. H. HARRISON

RPH Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

April 15,

## 17

I HEREBY CERTIFY, That I attended deceased from

April 4, 1928, to April 15, 1928.

that I last saw him alive on April 15, 1928.

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH\* was as follows:

Acute bridge of mercury poisoning

CONTRIBUTORY acute interstitial Nephritis

(Secondary) about nephritis

(duration) yrs. mos. ds.

Where was disease contracted

If not at place of death? At 1603 Linden Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Julius Bialostocky, M. D.

19 (Address) Colonial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

National Cemetery

4/17 1928

## 20 UNDERTAKER

ADDRESS

Sol. L. Linsman

1127 E. Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

R 17 1928

Spec. - 1-10-21 - M&T - 1500 Bks.

# HEALTH DEPARTMENT - CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32964

E 32964

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2725 Privately Ave ST. 9-47 WARD)

2. FULL NAME Elizabeth Campbell

(a) RESIDENCE NO. 2725 Privately Ave ST. 9-47 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 8 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 129  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kenneth Campbell

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1843

7 AGE Years 84 Months 5 Days 10 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Bucks (State or country) Ind.

10 NAME OF FATHER John C. Balster

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant E. W. Campbell (Address) 1610 E 31 St

15 17 1928 Registrar [Signature]

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1928

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1928, to April 17, 1928, that I last saw her alive on Apr. 17, 1928, and that death occurred, on the date stated above, at 7:54 m. The CAUSE OF DEATH\* was as follows:

Uraemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Perforation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Ind.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Chas. S. Jones M. D.

427 1928 (Address) 2878 Hartford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cemetery

20 UNDERTAKER Henry Sander & Sons Inc

DATE OF BURIAL

Apr. 19 1928

ADDRESS Broadway & Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32965

## CERTIFICATE OF DEATH.

66 E 32965

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 Carrollton Ave., St. 16-23 Ward)

2-FULL NAME Gertrude Hubbard

(a) RESIDENCE NO. 1000 Carrollton Ave., St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female Negro Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Howard Curtis

6 DATE OF BIRTH (month, day, and year)

May 15, 1893

7 AGE Years Months Days IF LESS than  
34 11 1 1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED Housework

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

10 NAME OF FATHER Henry Hubbard

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Webb

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Va.

14 Informant Mrs. Mary Hubbard

(Address) 1000 Carrollton Ave.

15 Filed 1928 19 C. HAYESON JONES, M.

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 April 16

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-inquiry and that said deceased came to her death  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

4/17/28 Address 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs.,.....mos.,.....ds. State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial

REMOVAL

UNDERTAKER

ADDRESS

Grove & A. Gibson 1735 H. Ave.  
Baltimore



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32966

## CERTIFICATE OF DEATH

E 32966

1-PLACE OF DEATH

Union Memorial Hsp. Tel

CITY OF BALTIMORE: (No.

334 + Calvert St

ST.

WARD

2-FULL NAME

Joseph Francis Ackerman

(a) RESIDENCE NO.

Weyman Park Apts 408 305

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mrs Joseph F. Ackerman

6 DATE OF BIRTH (month, day, and year)

May 29 1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

10

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mgr. &amp; Buyer Merchandise

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

?

9 BIRTHPLACE (city or town) (State or country)

Phila, Pa

10 NAME OF FATHER

Joseph Ackerman

11 BIRTHPLACE OF FATHER (city or town)

?

(State or country)

12 MAIDEN NAME OF MOTHER

Hannah Gallagher

13 BIRTHPLACE OF MOTHER (city or town)

?

(State or country)

14

Informant (Address)

Wife Mrs Ellen F. Ackerman Weyman Park Apts.

15

Filed

G. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 17 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr 17, 1928, to Apr 17, 1928,

that I last saw him alive on Apr 17, 1928,

and that death occurred, on the date stated above, at 4:50 P. M.

The CAUSE OF DEATH\* was as follows:

Peritonitis - ruptured gastric ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

?

if not at place of death?

Did an operation precede death?

Yes

Date of

Apr 17, 1928

Was there an autopsy?

None

What test confirmed diagnosis?

Operation

(Signed)

Wallace L. Swank, M. D.

, 19

(Address)

Union Memorial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

ADDRESS

Baltimore Md. Apr 18 1928

Stewart Morris Ball

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32967

## CERTIFICATE OF DEATH.

11<sup>2</sup> E 32967

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1131 N. Carey St. 16-23 Ward)2-FULL NAME Lillie M Williams(a) RESIDENCE NO. 1131 N. Carey St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced, HUSBAND of (or) WIFE of John Williams6 DATE OF BIRTH (month, day, and year) April 16 18937 AGE Years 35 Months \_\_\_\_\_ Days 9 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Chas Bennett11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)12 MAIDEN NAME OF MOTHER Ann Butler13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)14 Informant (Address) Annie Bennett  
1131 N. Carey St.15 Filed 1028 19Registrar RPK

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) Inquiry

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Indigestion (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 hours ds.CONTRIBUTORY Excess of diet (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Coroner) F. C. Kelsor M. D.(Address) North Ave & Down

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Auburn Cemetery Date of Burial 4/18/28

20 UNDERTAKER

Thomas G. Kelson Address 1303

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32968

## CERTIFICATE OF DEATH.

161-001  
E 32968

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1009 Whitcomb St. 16-22 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1009 Whitcomb St. 16-22 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 16<sup>th</sup> 19287 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md10 NAME OF FATHER John Hall11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md12 MAIDEN NAME OF MOTHER Lucilla Green13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md14 Informant Lucilla Green (Address) 1009 Whitcomb15 Filed 17-1928 19

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

(Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Premature Birth  
(9 months) 29 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) F. C. Luch M. D.(Address) North Ave & Division

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

mt zion cemetery

Date of Burial

4/18 1928

## 20 UNDERTAKER

Thomas G. Nelson

ADDRESS

1303 Pleasant

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32969

## CERTIFICATE OF DEATH.

101-001 ✓  
E 32969

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1345 N. Sticker 15-22 Ward)2-FULL NAME Abraham Young(a) RESIDENCE NO. 1345 N. Sticker 15-22 Ward(Usual place of abode)  
Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Child5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child6 DATE OF BIRTH (month, day, and year) Feb 27 - 19287 AGE Years Months Days 1 20 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) MD10 NAME OF FATHER Abraham Young11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) MD12 MAIDEN NAME OF MOTHER Louisa Kent13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) MD14 Informant Louisa Young (Address) 1345 N. Sticker15 Filed 17 1928 19. MD Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) Had that said deceased come to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia(duration) .....yrs. ....mos. 3 ds.

## CONTRIBUTORY (Secondary)

(Signed) J. B. Fink M. D.(Address) Coroner

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

mt Auburn cemetery April 18, 1928

20 UNDERTAKER

Thomas G. Nelson ADDRESS 1345 N. Sticker

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32970

## CERTIFICATE OF DEATH

129E 32970  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *President Hosp 16-27* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *815 Parish* St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**C.**Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)*Lillie Boddy*  
*815 Parish St.**G. HAMPSON JONES, M.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/14* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 13*, 19 *28*, to *Apr 14*, 19 *28*that I last saw him alive on *Apr 14*, 19 *28*

and that death occurred, on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*Cerebral*  
*nephritis Insult**unknown* (duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

CONTRIBUTORY

(Secondary)

*unknown* (duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

18 Where was disease contracted

if not at place of death? *unknown*Did an operation precede death? *no* Date of \_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Urinal*(Signed) *Bernard Harris, M. D.*, 19 \_\_\_\_ (Address) *President Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF REMOVAL OR

Date of Burial

*Sec. Co. Mol**Apr. 17* 19 *28*

20 UNDERTAKER

ADDRESS

*Wm. R. A. Elliott**Highland*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 18 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 3297E

## CERTIFICATE OF DEATH.

66 E 3297E

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 76-37 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. Not Known

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15 Filed

19

HAYDEN JONES

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY that I took charge of the

remains described above, held an Inquest  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

Inquest and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTOR

(Secondary)

17 Good alcohol over  
(duration) yrs. mos. hrs.  
17 Barium Sulfate  
(duration) yrs. mos. hrs.  
april 14 G.C. Blades M. D.  
(Coroner)  
, 19 (Address) 143 W. Bay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

X. R.—WRITE PLAINLY, WITH CARE.—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 18 1926

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32972

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. of death)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

53 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

APR 18 1928

H. J. JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from Mar 24, 1928, to April 17, 1928,

that I last saw him alive on April 17, 1928,

and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH\* was as follows:

Ulceration of the pylorus with malignant changes

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

Signed)

17 1928

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32973

## CERTIFICATE OF DEATH

E 32973

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Ind. Gen. Hospital 16-7* St. *16-7* Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

14

Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

April 11, 1928, to April 17, 1928,

that I last saw him alive on April 17, 1928,

and that death occurred, on the date stated above, at 6<sup>28</sup> a. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY

(Secondary)

18 Where was disease contracted?

if not at place of death?

Did an operation precede death?

Date of 4/11/28

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in Deaths from Violent Causes, state the Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 18 1928

15 Filed

19

JAMES H. JONES, M.D.  
Registrar

Registrar

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## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32974

E 32974

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Guilford Apts.* St. *12-19* Ward)2-FULL NAME *Savilla P. Crispin*(a) RESIDENCE NO. *Guilford Apts. North Guilford St.* WardLength of residence in city or town where death occurred *8* yrs. *0* mos. *0* ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John H. Crispin*6 DATE OF BIRTH (month, day, and year) *Feb. 2, 1842*7 AGE Years *86* Months *2* Days *11* IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto., Md.* (State or country)10 NAME OF FATHER *John Worley*11 BIRTHPLACE OF FATHER (City or town) *Baltimore, Md.* (State or country)12 MAIDEN NAME OF MOTHER *Sarah M. Smith*13 BIRTHPLACE OF MOTHER (city or town) *Chesapeake, Md.* (State or country)14 Informant *Mrs. Phillips Beatty* (Address) *3610 Clifton Ave.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 17, 1928*17 I HEREBY CERTIFY, That I attended deceased from *March 14, 1928* to *date of death*, that I last saw him alive on *April 15, 1928*, and that death occurred, on the date stated above, at *11:40 A.M.*

The CAUSE OF DEATH\* was as follows:

*Death was due to Broncho pneumonia*CONTRIBUTORY *Senility* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Place of death*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Urinal* (Signed) *Christy Du Noire, M.D.*19, (Address) *April 17, 1928*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*London Park Cem., April 18, 1928*

## 20 UNDERTAKER

ADDRESS

*James Mitchell & Sons 1900 Cutters Road*

N. B.--WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 18 1928

C. HANCOCK JONES, M.D. Registrar

E 32975

## HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ E 32975

## CERTIFICATE OF DEATH.

11-001

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 201 N. Rose St. 6-10 Ward)

## 2-FULL NAME

Mary E. Butterhoff

## (a) RESIDENCE NO.

201 N. Rose

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Male WhiteSingle

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Sept. 7/1919

## 7 AGE

## Years

## Months

## Days

IF LESS than 1 day.....hrs. or.....min.

879

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

at School

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town)

Balto

(State or country)

Md.

## 10 NAME OF FATHER

John J. Butterhoff

## 11 BIRTHPLACE OF FATHER (city or town)

Balto

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

M. E. Emery

## 13 BIRTHPLACE OF MOTHER (city or town)

Balto

(State or country)

## 14

Informant (Address)

Mr. John J. Butterhoff  
201 N. Rose St.

## 15 Filed

APR 18 1928

C. H. Jones, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19 28April 16

## 17

I HEREBY CERTIFY, That I attended deceased from

April 419 28April 16

that I last saw him alive on

April 16, 1928and that death occurred on the date stated above, at 7:40 m.

## The CAUSE OF DEATH\* as follows:

La grippe  
toxic Pericarditis

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

## 18 Where was disease contracted

If not at place of death!

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Boly RedeemerApril 20 1928

## 20 UNDERTAKER

ADDRESS

Jos. J. Idem 156 N. Luzerne ave.

N. B.—WRITE PLAINLY, WITH CARE.—Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32976

## CERTIFICATE OF DEATH.

E 32976

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1016 Hillock Ave Ward 16-22)

## 2-FULL NAME

(a) RESIDENCE NO. 1016 Hillock Ave Ward 16-22

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Euthene Edwards6 DATE OF BIRTH (month, day, and year) unknown7 AGE Years 60 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town), Phila Pa. (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Euthene Edwards  
1016 Hillock Ave

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1928

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
(duration) .....yrs. ....mos. 4 ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signature) J. E. Lusk M. D.  
(Address) Coroner

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Apr 18 192820 UNDERTAKER ADDRESS 1016 Hillock Ave

APR 18 1928

19 H. J. JONES, M. D.  
Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PRELIMINARY STATEMENT OF FACTS. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 32977. HEALTH DEPARTMENT—CITY OF BALTIMORE E 32977.

1-PLACE OF DEATH *Inn Hospital* CERTIFICATE OF DEATH.CITY OF BALTIMORE: (No. *25-77* ST. *90* WARD)2-FULL NAME *Henry Cywinski*(a) RESIDENCE NO. *926 Fairview Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs. mos. ds.ST. *90* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 10 - 1886*7 AGE Years *42* Months *4* Days *5* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Machinist*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Poland*10 NAME OF FATHER *Frank Cywinski*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*12 MAIDEN NAME OF MOTHER *Swiderski*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Poland*14 Informant *Kowalewski* (Address) *926 Fairview Ave*15 *C. HAYDEN JONES, M.D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-15-1928*17 I HEREBY CERTIFY, That I attended deceased from *4-13-1928*, to *4-15-1928*,that I last saw him alive on *4-15-1928* and that death occurred, on the date stated above, at *5 P.M.*

The CAUSE OF DEATH\* was as follows:

*Myocardial infarction*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *J. H. Edwards* M.D., 19 (Address) *Inn Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Cross A.C.C. April 19, 1928*

20 UNDERTAKER

ADDRESS

*J. W. Gogowski, 1930 Eastmoreland*

Information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 18 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32978

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 E. Lafayette Ave St. 12-14 WARD)

## 2-FULL NAME

Henrietta Royston

(a) RESIDENCE No. 403 E. Lafayette Ave St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Late Henry C. Royston

6 DATE OF BIRTH (month, day, and year) Aug 15, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	8	1	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Winchester, Va.

10 NAME OF FATHER Benjamin F. Evans

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Ann Mouldin

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Washington, D.C.

14

Informant Mrs. M. F. Kilchenstein  
(Address) 403 E. Lafayette Ave.

APR 18 1928

HARRISON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16/28

17 I HEREBY CERTIFY, That I attended deceased from February 5th, 28 to April 16, 1928, that I last saw her alive on April 25, 1928, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH\* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY Cerebral Apoplexy-Rt  
(Secondary)

Hemiplegia (duration) yrs. 10 mos. 1 ds.

18 Where was disease contracted  
if not at place of death? At home

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. S. Hatter, M. D.

4/17/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmount

4-18th 1928

20 UNDERTAKER

ADDRESS

Wm Cook

602 E. North Ave

N. B.—WRITE PLAINLY, WITH CAREFULNESS. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

213544  
E 32979Vulgaris  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *HOPKINS HOSPITAL*CITY OF BALTIMORE: (No. *3-4* ST. *3-4* WARD)2-FULL NAME *Hattie Vulgaris*(a) RESIDENCE No. *321 S. Broadway*

(Usual place of abode)

Length of residence in city or town where death occurred *22* yrs. mos. ds.How long in U. S., if of foreign birth? *22* yrs. mos. ds.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 32979

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced *HUSBAND of* (or) WIFE of *James Vulgaris*6 DATE OF BIRTH (month, day, and year) *Aug 15, 1884*7 AGE Years *43* Months *8* Days *1* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Greece* (State or country)10 NAME OF FATHER *Nick Anagnostis*11 BIRTHPLACE OF FATHER (city or town) *Greece* (State or country)12 MAIDEN NAME OF MOTHER *Catherine Papadakis*13 BIRTHPLACE OF MOTHER (city or town) *Greece* (State or country)14 Informant *Records* (Address)15 APR 13 1928 *W. H. JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 16 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 11, 1928* to *April 16, 1928* that I last saw her alive on *April 16, 1928* and that death occurred, on the date stated above, at *7:02 P. m.*

The CAUSE OF DEATH\* was as follows:

*Purpural Septicemia (as Bacillus)*(duration) yrs. mos. *2* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *W. H. Jones*, M. D.4-17, 1928 (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

*Wood Lawn*

## DATE OF BURIAL

*4-18 1928*

## UNDERTAKER

*Wm Cook*

## ADDRESS

*502 E north*

Information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 42 E. York St.St., 22-6 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Henry Krause.(a) RESIDENCE NO. 42 E. York St.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male.White.Widower.6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDo not know.

6 DATE OF BIRTH (month, day, and year)

September 30, 1861

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.66616

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

New Jersey.

10 NAME OF FATHER

Henry Krause.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Catherine Newbeck

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany.

14

Informant Edward Krause. (brother)(Address) 40 Gautier Ave. Jersey City.

15

Filed APR 18 1928

19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 15, 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiryand that said deceased came to his death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular disease of the Heart.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

4/18 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death

.....yrs. ....mos. ....ds.

In the

State

.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Jersey City N.J. Via Amer River ExpressApr 18 1928

20 UNDERTAKER

ADDRESS

John F. Denny715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 32981

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32981

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *1346 N. Fremont St.*  
CITY OF BALTIMORE: (No. *15-23* ST. *15-23* WARD)

REGISTERED NO. *107-003*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Viola Petrus*  
(a) RESIDENCE NO. *1846 N. Fremont* ST. *15-23* WARD *15-23*  
(Usual place of abode)  
Length of residence in city or town where death occurred *Life* yrs. mos. ds. Now long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 6 1928*

7 AGE Years *22* Months *2* Days *10* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housekeeper*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) *City* (State or country)

10 NAME OF FATHER *William Petrus*

11 BIRTHPLACE OF FATHER (city or town) *Ind* (State or country)

12 MAIDEN NAME OF MOTHER *Cornelia Jones*

13 BIRTHPLACE OF MOTHER (city or town) *Ind* (State or country)

14 Informant *William Petrus Jr* (Address) *1846 N. Fremont St.*

15 Filed *18 1928* REGISTRAR *R. J. Jones*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 16 1928*

17 I HEREBY CERTIFY, That I attended deceased from *March 24*, 1928, to *April 16*, 1928, that I last saw her alive on *April 15*, 1928, and that death occurred, on the date stated above, at *7.15 A. m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Abscess* (duration) *2* yrs. *2* mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) *2* yrs. *2* mos. *2* ds.

18 Where was disease contracted if not at place of death? *Unknown*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *None*

(Signed) *W. F. Kendrick* M. D. (Address) *2221 E. Baltimore St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

*Undertaker* *April 18 1928*  
*Virginia A. Brooks 14637 Carey*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 32982  
1-PLACE OF DEATHCITY OF BALTIMORE: (No. 1617 Edmondson Ave. WARD)2-FULL NAME Elizabeth H. Bryan(a) RESIDENCE NO. 1617 Edmondson Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 90 E 32982

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred S. Bryan6 DATE OF BIRTH (month, day, and year) Feb 7 1860

7 AGE

Years 68Months 2Days 9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Irishman10 NAME OF FATHER Geo B Mc Cubbin11 BIRTHPLACE OF FATHER (city or town) (State or country) Irish12 MAIDEN NAME OF MOTHER Anna Wilson13 BIRTHPLACE OF MOTHER (city or town) (State or country) Irish

14

Informant (Address) Alfred S. Bryan  
1617 Edmondson Ave.

15

Filed

H. H. JONES, JR.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1928

17

HEREBY CERTIFY, That I attended deceased from Dec 18 1927, to April 16 1928, that I last saw her alive on April 16 1928, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH\* was as follows:

Chronic Myocardial Degeneration(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Autopsy(Signed) H. H. Jones, Jr.

M. D.

, 19 (Address) 1617 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 18 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32983

## CERTIFICATE OF DEATH.

E 32983

1-PLACE OF DEATH Found floating in the water at

City of BALTIMORE: (No. Foot of Woodall St., St., Ward)

2-FULL NAME Frederick A. Greeneisen.

(a) RESIDENCE NO. 705 E. 41st. St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mo. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male. White. Single.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

IIIIIIII,-

6 DATE OF BIRTH (month, day, and year)

July 12, 1865

7 AGE Years Months Days IF LESS than  
1 day.....hrs.  
or.....min.

62

8

14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired letter carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Frederick Greeneisen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Lula E. Markolf.  
(Address) 705 E. 41st St.

15 Filed 18 1928, 19 C. H. JONES, M. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928  
Missing March 28, Body found April 16, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Drowning.  
probably accidental.

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

4/17 19 28 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Druid Ridge Apr. 18 1928

20 UNDERTAKER

George J. Smith ADDRESS 532 Hollins

E 32984

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32984

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Balto City Hosp.*CITY OF BALTIMORE; (No. *Balto Md* ST. *90* WARD)2-FULL NAME *Belle Giddings*(a) RESIDENCE NO. *512 W. Cross St.* ST. *90* WARD(Usual place of abode)  
Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Blk* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of or WIFE of *William Giddings*6 DATE OF BIRTH (month, day, and year) *1872*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *56*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Factory*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Stephen Camper*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Sarah Thomas*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*14 Informant *Balto City Hosp.* (Address) *Balto Md*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-15-1928*17 I HEREBY CERTIFY, That I attended deceased from *3-31-1928* to *4-15-1928*that I last saw her alive on *4-14-1928*and that death occurred, on the date stated above, at *4:45 A.M.*

The CAUSE OF DEATH was as follows:

*Mitral Insufficiency*  
*Hypertension*

(duration) yrs. mos. ds.

CONTRIBUTORY *Advanced Arteriosclerosis*  
(Secondary) *Agitated Depression*  
(duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Autopsy*(Signed) *Harry F. Giddings*Address *Baltimore City Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St Auburn Cemo* DATE OF BURIAL *4/18/1928*20 UNDERTAKER *Byron Knight 1218 N. Cherry St.* ADDRESS

APR 18 1928

C. F. Jones, Registrar

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.





E 32986

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 1001  
101 E 32986

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1320 N. Carey St. St. 15-22 Ward)

Registered No. ....

## 2-FULL NAME

Albert Harris

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) Residence No.

1320 N. Carey St.

St.

Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

8 yrs.6 mos.21 ds.

Now long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

M.

4-COLOR OR RACE,

C5-Single,  
Married, Single  
Widowed,  
or Divorced,  
(Write the word.)5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

Sept 25, 1919

7-AGE,

23

If LESS than 1 day,

8 yrs. 6 mos. 21 ds.

hrs. or min.

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work.at home(b) General nature of industry,  
business, or establishment in  
which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town)  
(State or Country),Baltimore Md.10-NAME OF  
FATHER,Alfred Harris11-BIRTHPLACE  
OF FATHER (city or town)  
(State or Country)Anne Arundel Co12-MAIDEN NAME  
OF MOTHER,Rosetta Queen13-BIRTHPLACE  
OF MOTHER (city or town)  
(State or Country)Anne Arundel Co

14-

(Informant) Rosetta Harris(Address) 1320 N. Carey St.

15-

APR 18 1928

C. H. HARRIS, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-18-28

17- I HEREBY CERTIFY, That I attended deceased from

4-15- 19 28, to 4-18, 19 28.that I last saw him alive on 4-18, 19 28.and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(Duration) yrs. mos. 5 ds.CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. M. Lawrence, M. D.4-18, 19 28 (Address) 1232 W. Mosher St.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL,

St. Mark A. G. Coma Apr 20, 19 28

20-UNDERTAKER

ADDRESS

John W. Cross 1400 Mosher

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state CAUSE OF DEATH. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 32987

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 2511 E. Preston St. 8-12 Ward)

2-FULL NAME Sister Mary Diameda C. S. F. (Bndict) Higgins

(a) RESIDENCE NO. 2511 E. Preston St. 8-12 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 0 mos. 0 da. How long in U. S. if of foreign birth 23 yrs. 0 mos. 0 da.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1, 1894

7 AGE Years 34 Months - Days - IF LESS than 1 day - hrs. - or - min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER Michael Higgins

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Bridget Lyons

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address) Sister Superior of St. Patrick's

15 Filed

1928

O. A. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

April 16, 1928, to April 17, 1928

that I last saw her alive on April 17, 1928

and that death occurred, on the date stated above, at 5-40 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) - yrs. - mos. 1 da.

CONTRIBUTORY Arteriosclerosis (Secondary)

Hypertension (duration) ? yrs. - mos. - da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Evidence

(Signed) Mrs. B. Hubert, M. D.

(Address) 2802 Starford Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery April 19, 1928

20 UNDERTAKER

ADDRESS

Henry Hoeck Inc 1301 E. Eager



✓  
ORE 101-001  
E 32989

### CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1328 Hanover ST.,        WARD

Length of residence in city or town where death occurred 20 yrs. mos. ds. Now long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 17 19 28

17 I HEREBY CERTIFY, That I attended deceased from  
april 14 19 28, to April 7 19 28  
that I last saw h alive on April 17 19 28  
and that death occurred, on the date stated above, at 830 H m.

6 DATE OF BIRTH (month, day, and year) Oct. 1 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs or.....min.
	38	6	16	

*Pleuris Pneumonia*

(duration) yrs. mos. 4 ds.

CONTRIBUTORY *Exhaustion*  
(Secondary)

..... (duration) ..... yrs. .... mos. .. 7 .. ds.

18 Where was disease contracted \_\_\_\_\_

if not at place of death? .....

Did an operation precede death? ☒ Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? *Chemically*

(Signed) W. H. Campbell M. D.

28

177, 1944 - (Address) 1644 1/2 Ave. - 17

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL	DATE OF BURIAL
---	----------------

MOBILE  
Candice M. G. 4/30/93

20 UNDERTAKER	ADDRESS
1	
2	
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J. F. M. - 6 mths 120 { 4 w

PR 18 1928







## HEALTH DEPARTMENT—CITY OF BALTIMORE

B-32992

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Nathaniel Moulden

(a) RESIDENCE NO.

1366 N Carey

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male black

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

3/16/21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

Nathaniel Moulden

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Bernie Barney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

C. HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-17

19 28

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1928, to April 17, 1928, that I last saw him alive on April 17, 1928,

and that death occurred, on the date stated above, at 3:45 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? NO Date of

Was there an autopsy? yes

What test confirmed diagnosis?

Autopsy

(Signed) Allan Blaisdell, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

M. J. Jones, 364 N. Carey

B.—WRITE PLAINLY, WITH NO FADING. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 18 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 32993

## CERTIFICATE OF DEATH.

90 E 32993

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 516 N Calhoun St. 4-27 Ward)2-FULL NAME Mary Marie Myers(a) RESIDENCE NO. 516 N Calhoun St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Col. 5 Single, Married, Widowed, or Divorced, (write the word) Mar.5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Mahamitt6 DATE OF BIRTH (month, day, and year) unknown7 AGE Years 55 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) 7. Baeto (State or country) \_\_\_\_\_10 NAME OF FATHER Oliver Myers11 BIRTHPLACE OF FATHER (city or town) md (State or country) \_\_\_\_\_12 MAIDEN NAME OF MOTHER Charity Marshall13 BIRTHPLACE OF MOTHER (city or town) md (State or country) \_\_\_\_\_14 Informant Lillian Jackson (Address) 516 N Calhoun

PR 18-1928 C. HARRISON JONES, M. D. Registrar

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16/28 19 2817 I HEREBY CERTIFY, That I attended deceased from March 15 19 28 to April 16 19 28, that I last saw him alive on April 15 19 28, and that death occurred, on the date stated above, at 8:45 am.

The CAUSE OF DEATH\* was as follows:

Organic Disease of Heart

CONTRIBUTORY (Secondary)

(duration) yrs. 18 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death HeDid an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? 277(Signed) W. J. H. Jones, M. D.19 (Address) 939 N. Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Lincoln Park Cemetery April 19 28

20 UNDERTAKER

Mrs. Kate R. Williams ADDRESS 322v. Schneider

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.



E 32994

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32994

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *236*)St. *18* Ward *76*

Registered No. C.....

2-FULL NAME

*Louise Chandler*  
*236 No. Chandler*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *4*)

St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*Black*5-Single, Married, Widowed, or Divorced, (Write the word.) *Mar.*

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

*50*

If LESS than 1 day,

yrs., mos., ds.

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*087*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, *John*

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, *Ann*

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

C. HANCOCK JONES, M.D.

PR 18 1928

2370

THE MORGUE.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Mar 28*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY That I took charge of the

remains described above, held an *Inquiry*

(Inquest, autopsy or inquiry.)

hereon and from the evidence obtained by said *Inquiry*

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Myocardial Steuosis*  
*Duration* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*aps* *Blades*  
*43 No. Bway*  
192 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL, 19...

20-UNDERTAKER,

ADDRESS

Commissioner Health

APR 18 1928

PAT. W. E. WORNALL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32995

## CERTIFICATE OF DEATH.

E 32995

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Store S.E. on La Fayette St. 1st Ward*)

## 2-FULL NAME

(a) RESIDENCE NO. *1602 W. La Fayette*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**Col**unknown*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.*about 45*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)*Mr. Green  
1602 W. La Fayette*

18 1928

G. HARRISON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Coronary Heart Disease  
(Atherosclerosis)  
Sudden*CONTRIBUTORY  
(Secondary)

(duration)

(duration)

yrs.

mos.

ds.

(Signed)

(Coroner)

M. D.

1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

18 1928

G. HARRISON JONES, M. D.

Registrar

E 32996

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 E 32996

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3902 Fernwood Ave. ST. 26 WARD)

2. FULL NAME *Hannah M. Evans*

(a) RESIDENCE NO. 3902 Fernwood Ave. ST. 26 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 67 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*6a If ~~married~~ widowed, ~~widowed~~ *Widowed*  
(or) WIFE of *David M. Evans*6 DATE OF BIRTH (month, day, and year) *July 20, 1860*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*67 8 26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*  
(State or country)10 NAME OF FATHER *John Williams*11 BIRTHPLACE OF FATHER (city or town) *Males*  
(State or country)12 MAIDEN NAME OF MOTHER *Sarah Davis*13 BIRTHPLACE OF MOTHER (city or town) *Males*  
(State or country)14 Informant *John Howard Evans*  
(Address) *3902 Fernwood Ave. ST. 26 WARD*15 Filed *1928* 19 *C. HAMMOND*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 16 1928*17 I HEREBY CERTIFY, That I attended deceased from *Nov. 24 1927* to *April 16 1928*, that I last saw her alive on *April 16 1928*, and that death occurred, on the date stated above, at *10.45 a.m.* The CAUSE OF DEATH\* was as follows:*Cancer of intestines.*(duration) yrs. *5* mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Edw. Lochboller* M. D.19 (Address) *806 S. 3rd St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Oaklawn Cemetery**April 19, 1928*

20 UNDERTAKER

ADDRESS

*George W. Zinkler**1737 E. Egan*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 32997.

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hope St. 16-22 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

C. HARRISON JONES, M. D.

19

APR 18 1928

Register

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

17 I HEREBY CERTIFY, That I took charge of remains described above, held an Inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)  
And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured Skull  
Accident stuck by side  
car tracks

(duration) yrs. mos. ds. 3

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. B. Smith M. D.

(Address) Coroner N. W. N.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Edmondson Ave. Ext. Bldg. Co.  
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial REMOVAL

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 18 1928





E 32999

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 32999

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 157 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Yuell(a) RESIDENCE NO. 526 East ST. 157 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds.How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE Colored5 Single, Married, Widowed, or Divorced, (write the word) ?5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?

7 AGE

76

Years

Months

Days

If LESS than 1 day, 0 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work seaman(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica10 NAME OF FATHER ?11 BIRTHPLACE OF FATHER (city or town) (State or country) ?12 MAIDEN NAME OF MOTHER ?13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14

Informant (Address) Records

15

FIC 18 1928

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/1928

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 26, 1920, to April 16, 1928that I last saw him alive on April 16, 1928and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) 4 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) HypertensionArteriosclerosis ? yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? general + lab(Signed) C. Hampton Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Asbury Cem.4/19/1928

20 UNDERTAKER

ADDRESS

Byron Wright 1218 McElders St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EXAMINERS AND STATE PHYSICIANS SHOULD STATE EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD STATE EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33001

E 33001

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Anna Kalter

REGISTERED NO.

CITY OF BALTIMORE: (No. 1130 Scott

ST., 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Kalter

(a) RESIDENCE NO. 1130 Scott

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

22 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Henry Kalter

6 DATE OF BIRTH (month, day, and year) March 7, 1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

1

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Norway

10 NAME OF FATHER

Christian Hansen

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Norway

12 MAIDEN NAME OF MOTHER

Eli Holt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Norway

14

Informant (Address)

Henry Kalter 1130 Scott Street

15

Filed

C. H. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 19 28

17

I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1928 to April 17, 1928.

that I last saw her alive on April 16, 1928.

and that death occurred, on the date stated above, at 6.25 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Uterus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Albumen Hemorrhage

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical CX

(Signed) J. M. Lempert, M. D.

4/17/28 (Address) 3409 Calloway Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery

Apr. 19 19 28

20 UNDERTAKER

ADDRESS

1001 W. Baltimore St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33002

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *742 E. Fort Ave.* ST. *24-33* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *742 E. Fort Ave.* ST. *24-33* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *75* yrs. *1* mos. *12* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced. (write the word)

*Widowed Divorced*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Ellie Rebstock*

6 DATE OF BIRTH (month, day, and year)

*Apr. 3<sup>d</sup>, 1853*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*75**1**12*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Brick-layer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*City*

10 NAME OF FATHER

*Charles Rebstock*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Holland*

14

Informant (Address)

*Mrs. Foot 742 E. Fort Ave. (daughter)*

15

Filed

*C. HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 15<sup>th</sup> 1928*

I HEREBY CERTIFY, That I attended deceased from

*4, 4, 1928, to 11, 15, 1928.*that I last saw him alive on *11, 15, 1928*and that death occurred, on the date stated above, at *11 p. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Valv Heart Disease*(duration) yrs. *15* mos. ds.CONTRIBUTORY (Secondary) *chron nephritis*(duration) yrs. mos. *14* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *L. J. Burlington*, M. D.(Address) *102 E Fort Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Cedar Hill Cemetery*

DATE OF BURIAL

*4/19/28*

20 UNDERTAKER

*E. J. Fanning, Inc. 1440 Battery*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33003

## CERTIFICATE OF DEATH

57 E 33003

1-PLACE OF DEATH *Baltimore, Md.*

REGISTERED NO.

City of BALTIMORE: (No. *Washington Apt., Chas. + Mt. Vernon Place* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Martha B. Caperton*(a) RESIDENCE NO. *Charles St. + Mt. Vernon S. Place* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *26* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*female**white**widowed*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Hugh Caperton*

6 DATE OF BIRTH (month, day, and year)

*Nov. 22, 1856*

7 AGE

Years

Months

Days

IF LESS than  
1 day—hrs.  
or—min..*71**6**24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Amelia County  
Virginia*

10 NAME OF FATHER

*Dr. William C. Booth*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Virginia*

12 MAIDEN NAME OF MOTHER

*Sarah Jane Baughan*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Alabama*

14

Informant  
(Address)*Benjamin V. Booth  
Danville, Va.*

C. HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 18th 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 14, 1928, to April 18, 1928,*that I last saw her alive on *April 17th, 1928,*and that death occurred, on the date stated above, at *4 a. m.*

The CAUSE OF DEATH\* was as follows:

*Psychosis -**Complicated with Diabetes*(duration) *1* yrs. *-* mos. *-* da.

CONTRIBUTORY

(Secondary)

(duration) *-* yrs. *-* mos. *-* da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of *none*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *Eugene Douglas*, M. D.

, 19

(Address) *3043 St. Paul Street*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Richmond, Va.**April 19, 1928*

20 UNDERTAKER

ADDRESS

*John O. Mitchell + Sons**1900 Eutaw Place*

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 18 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33004

E 33004

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 17 N. Gilmore St. 19-27 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 17 N. Gilmore St. 19-27 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 87 Months 5 Days 9 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Watchman(b) General nature of industry, business, or establishment in which employed (or employer) Highways Commission(c) Name of employer Baltimore City

## 9 BIRTHPLACE (city or town)

(State or country) Canazoharie N. Y.10 NAME OF FATHER Abram Wood

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown12 MAIDEN NAME OF MOTHER Ann Wild

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

## PARENTS

14 Informant (Address)

15 Filed G. HAMPTON JONES, M. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/1928

17

I HEREBY CERTIFY, That I attended deceased from 4/12/1928 to 4/17/1928, that I last saw him alive on 4/17/28, and that death occurred, on the date stated above, at 9:20 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
(duration) ..... yrs. .... mos. 3 ds.

## CONTRIBUTORY

(Secondary)

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of .....Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leander E. Beach, M. D.19 (Address) 2229 St Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Date of Burial

Canazoharie N. Y. April 28

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 33005

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33005

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *8-45* WARD)2-FULL NAME *Beitha Kates*(a) RESIDENCE NO. *1775 Harley Ave.* ST. *8-45* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced *HUSBAND of* (or) WIFE of *Peter Kates*6 DATE OF BIRTH (month, day, and year) *Jan. 13, 1893*7 AGE Years *35* Months *3* Days *3* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *At Home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balt. Md.*10 NAME OF FATHER *Stanislaus Kulski*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*12 MAIDEN NAME OF MOTHER *Mary Sporney*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Poland*14 Informant *Peter Kates* (Address) *1775 Harley Ave.*15 *PR 18 1928* FILE *C. 19* HADISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/16/28* 1917 I HEREBY CERTIFY, That I attended deceased from *3/31/28*, 19 to *4/16/28*, 19, that I last saw her alive on *4/16/28*, 19, and that death occurred, on the date stated above, at *6:30 P. M.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary tuberculosis*

(duration) yrs. mos. ds.

CONTRIBUTORY *pulmonary hemorrhage* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *H. Laurena F. Jones*, M. D., 19 (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Holy Rosary*

DATE OF BURIAL

*4/19/1928*

20 UNDERTAKER

*John G. Connelly*

ADDRESS

*Essex*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

212897  
E 33006

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

21 E 33006

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST. 16-23 WARD)

2-FULL NAME Baby Boddie

(a) RESIDENCE NO. 1145 Canollton

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

male black

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22 - 1918

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

26

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER Ruth

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

1923

HAUF JONES, R.  
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
April 7, 1928 to April 17, 1928,  
that I last saw him alive on April 17, 1928,  
and that death occurred, on the date stated above, at 8 8 m.

The CAUSE OF DEATH\* was as follows:

Empyema which began on nose +  
spread as far as upper half of lungs  
gaining access to peritoneum via  
umbilicus (duration) yrs. mos. 12 ds.

CONTRIBUTORY Sepsis + peritonitis  
(Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted Obstetrical service  
if not at place of death? Johns Hopkins Hospital

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture  
Aspiration peritoneal fluid  
(Signed) Allen Blakson M. D.

4/19, 1928 (Address) The Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Johns Hopkins Hosp.

4-19-28

UNDERTAKER

ADDRESS

George W. Giblin

1785

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 33007

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore Hospital 11-24* WARD)

2-FULL NAME

*Elanus Steunach*

(a) RESIDENCE NO. *1028 N. Eutan*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred *10* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

*Female Col.*

*Col.*

*Married*

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

*John Steunach*

6 DATE OF BIRTH (month, day, and year)

*1891*

7 AGE

Years *37*

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Washington D. C.*

10 NAME OF FATHER

*Joshua Byrd*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Florida*

12 MAIDEN NAME OF MOTHER

*Bergman Phelan*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Fla*

14

Informant (Address)

*John Steunach 1028 N. Eutan St.*

15

Filed

*1928 G. HANCOCK JONES, Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 18 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*4-1-1928*, to *4-18-1928*

that I last saw her alive on *4-18-1928*

and that death occurred, on the date stated above, at *12:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Labor Pneumonia - Acute Appendicitis*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

*Shigella Proteus*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Home*

Did an operation precede death? *Yes* Date of *4-16-28*

Was there an autopsy? *Yes*

What test confirmed diagnosis?

*Autopsy*

(Signed)

*Blanchard M. D.*

, 19 (Address)

*Baldy City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Washington D.C.*

*4/20 1928*

20 BURIAL

ADDRESS

*Sumner Newslay Middle*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33008

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

3032 Walbrook Ave.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 15 WARD

2-FULL NAME

Amanda C Matthews

(a) RESIDENCE NO.

3032 Walbrook Ave.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 27 1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

70 70

5

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Thomas Matthews

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Sarah White

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Jennie Wilkinson 3032 Walbrook Ave

15

Filed

G. HANFORD JONES, Jr.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 18 1928

17

I HEREBY CERTIFY, That I attended deceased from

July 16<sup>th</sup>, 1926, to April 18, 1928.

that last saw her alive on 4/18, 1928

and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH\* was as follows:

Nephritis. Asthma-Senility

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Cardio-Vascular Renal Collapse - (duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) M. R. Sykes, M. D.

, 19 (Address) 3048 Walbrook Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Pocomoke City - Md.

Apr 21 1928

20 UNDERTAKER

ADDRESS

Joseph Sykes

1608 W. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33009

X 182 E 33009

## 1-PLACE OF DEATH

Found floating in the water at  
City of BALTIMORE: (No. Foot of Henry St. St. Ward)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME James West.

(a) RESIDENCE NO. Glass, Va. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male. White. Single.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year)  
October 24, 19107 AGE Years Months Days IF LESS than  
17 5 10 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea man.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Norfolk Va.

10 NAME OF FATHER Julius West.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Ippia Armstead.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Julius West. (father)

(Address) 43 E. York St.

15 Filed 1928 G. HAMPSON JONES, M. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)  
Missing Apl. 8, Body found April 16, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Drowning.  
probably accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner)

4/19, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL

Satan Balt 60 April 18, 28

20 UNDERTAKER

ADDRESS

Chenoweth 3108

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PARENTS



HEALTH DEPARTMENT—CITY OF BALTIMORE **E 33010**

## CERTIFICATE OF DEATH.

## 1.—PLACE OF DEATH

CITY OF BALTIMORE: (No. **26-37** ST. **90** WARD)2.—FULL NAME **Charles Eklund**(a) RESIDENCE No. **4023 Eastern Ave.** WARD

(Usual place of abode)

Length of residence in city or town where death occurred **40** yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Male** 4 COLOR OR RACE **white** 5 Single, Married, Widowed, or Divorced, (write the word) **Widowed**5a If married, widowed, or divorced, HUSBAND of (or) WIFE of **Josephine Eklund**6 DATE OF BIRTH (month, day, and year) **Oct 29 - 1858**

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

**69****5****18**

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

**Salvage**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

**Sweden**10 NAME OF FATHER **John Eklund**

11 BIRTHPLACE OF FATHER (city or town) (State or country)

**Sweden**12 MAIDEN NAME OF MOTHER **Julie Gustafson**

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

**Sweden**

14

Informant (Address)

**Records**

15

HARVEY JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **4/17/1928**

17

I HEREBY CERTIFY, That I attended deceased from

**April 7, 1928, to April 17, 1928.**that I last saw him on **April 17, 1928.**and that death occurred, on the date stated above, at **4:15 A. M.**

The CAUSE OF DEATH\* was as follows:

**Subacute pneumonia**(duration) yrs. mos. **12** ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? **no** Date ofWas there an autopsy? **yes**

What test confirmed diagnosis?

(Signed) **C. J. Jones, M. D.**

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

**Mount Carmel Church**

DATE OF BURIAL

**Apr 20 1928**

20 UNDERTAKER

**John Ullrich**

ADDRESS

**8008 Belmont**

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 19 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 33011

## CERTIFICATE OF DEATH.

31 E 33011

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 N. Bond St.

ST. 8-17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Harry Ward

(a) RESIDENCE NO. 1521 N. Bond St.

(Usual place of abode)

Lifetime.

Length of residence in city or town where death occurred

yrs. mos.

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of (or) WIFE of Mary C. Ward.

6 DATE OF BIRTH (month, day, and year) Sept. 18th. 1856

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
71 6 30 27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Business.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Thomas H. Ward.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OR MOTHER Kate Fuhr.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Mary C. Ward.  
(Address) 1521 N. Bond St.

15 Filed APR 19 1928 JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th. 1928.

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 17, 1928, that I last saw him alive on April 17, 1928, and that death occurred, on the date stated above, at 11 A. M.  
The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Apr 18 1928 (Address) 1228 Riverside

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL  
Greenmount Cemetery.

DATE OF BURIAL

Apr. 20, 1928

ADDRESS

UNDERTAKER

Chas. A. Wauson 1180 Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33012

E 33012

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *46* WARD)2. FULL NAME *William A. McSweeney*(a) RESIDENCE NO. *723 E 21st St.* ST. *46* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Lifetime* mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Widower*5a If married, widowed, or divorced HUSBAND or (or) WIFE of *Mary A. McSweeney*6 DATE OF BIRTH (month, day, and year) *May 15 - 1884*

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs or ... min

*43**11**3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Clerk*9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Wm McSweeney*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Clara Hurlibey*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *Miss Margt McSweeney**723 E 21st St*

15

APR 19 1928

HARRY R. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 18 - 1928*

17

I HEREBY CERTIFY, That I attended deceased from *4-7-28*, 19, to *4-18-28*, 19,that I last saw him alive on *4-18-28*, 19,and that death occurred, on the date stated above, at *10:35 a.m.*

The CAUSE OF DEATH\* was as follows:

*Changueated Hernia  
Cardiac decompensation  
Chronic nephritis -*(duration) *5* yrs. mos. ds.CONTRIBUTORY (Secondary) *Tuberculosis*(duration) yrs. mos. *4* ds.18 Where was disease contracted if not at place of death? *2*Did an operation precede death? *yes* Date of *4-7-28*Was there an autopsy? *no*What test confirmed diagnosis? *clinical*(Signed) *H. Lawrence Fahmy*, M. D., 19 (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Cathedral Cemetery**4/21 1928*

UNDERTAKER

ADDRESS

*Chas T. Wacker* *1180 Mt Royal Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33013

E 33013

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1033 Spence*)ST. *25-72* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

*Helen Grigoriu*

## (a) RESIDENCE NO.

*1033 Spence*

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Dec. 5, 1927*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*0**4**13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto. Md.*

10 NAME OF FATHER

*Roman Grigoriu*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Poland*

12 MAIDEN NAME OF MOTHER

*Mary Klock*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Poland*

PARENTS

14 Informant  
(Address)*Roman Grigoriu*  
*1033 Spence St*

15

File

*HELEN GRIGORIU*  
*1033 Spence St*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 18 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*April 16, 1928* to *April 18, 1928*that I last saw her alive on *April 18, 1928*and that death occurred, on the date stated above, at *4.30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Bronchitis - pneumonia*(duration) *0* yrs. *0* mos. *2* ds.CONTRIBUTORY  
(Secondary)*acute myocarditis*(duration) *0* yrs. *0* mos. *2* ds.18 Where was disease contracted  
if not at place of death?*Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

*Examination*

(Signed)

*Chas. S. Heston*, M. D.

, 19 (Address)

*1730 Linden Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Polish Cemetery**4/20 1928*

20 UNDERTAKER

ADDRESS

*Edward Joulon**2259 W. 1st St.*

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33014

## CERTIFICATE OF DEATH.

90 E 33014

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3046 O'Donnell St., 1 Ward)2-FULL NAME Mary S. E. Hurtt(a) RESIDENCE NO. 3046 O'Donnell St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of the late Robert M. Hurtt (or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept. 13 - 18597 AGE 68 Years 7 Months 13 Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Id. (State or country)10 NAME OF FATHER Joseph W. Haugler11 BIRTHPLACE OF FATHER (city or town) Id. (State or country)12 MAIDEN NAME OF MOTHER Margt. E. Young13 BIRTHPLACE OF MOTHER (city or town) Id. (State or country)14 Informant Lanissa M. Opie (Daughter) (Address) 3046 O. Donnell St.15 Filed 19 1928 H. J. Jones Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 192817 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial InfarctionCONTRIBUTORY Arteriosclerosis (duration) yrs. mos. ds.9 to 10 (duration) yrs. mos. ds.(Signed) G. C. Blakes M. D.

(Coroner)

19 (Address) 1437 W. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

where was disease contracted, if not at place of death

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cemetery Date of Burial April 18 192819 UNDERTAKER Lilly & Zeller Inc. ADDRESS 403 S. W. 1st St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33015

129 E 33015

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *10* *St. Joseph's Hospital* ST., *1-2* WARD)2. FULL NAME *Frank Sanders* (FRANK SANDERS.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *404 S. Robinson* ST., *1* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *63* yrs. *3* mos. *6* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male* *White* *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Margaret Sanders.*6 DATE OF BIRTH (month, day, and year) *Jan. 11<sup>th</sup> 1866*

7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or min.

*63**3**6*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Policeman* *ob!*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Balto. City Dept*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto. Md.*10 NAME OF FATHER *John Sanders*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*12 MAIDEN NAME OF MOTHER *Josephine Meyer*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Margaret Sanders*  
*404 S. Robinson St.*

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/17/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*4/8/28*, 19to *4/17/28*, 19that I last saw him alive on *4/17/28*, 19and that death occurred, on the date stated above, at *6:20 PM*

The CAUSE OF DEATH\* was as follows:

*radix ossicular renal*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*menia*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No*

Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*H. Lawrence Zahm*, M. D.

19

(Address)

*St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

*Sacred Heart Cemetery**April 20, 1928*

UNDERTAKER

*Lilly + John Doe*

ADDRESS

*400 S. Wolfe St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 33016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31~ E 33016

1-PLACE OF DEATH

City of BALTIMORE: (No. 2242 Cecil Ave St. 9-46 Ward)

2-FULL NAME

James E. Keen

(a) RESIDENCE NO.

2242 Cecil Ave

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male white single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1/1894

7 AGE 34 Years Months Days IF LESS than 1 day.....hrs. or.....min. 31 2 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City

(c) Name of employer Incinerator

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

10 NAME OF FATHER Geo. A. Keen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Alice Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Alice Stevens & Keen. (Address) 1954 Patterson Park Ave

15 FILED APR 19 1928 H. J. JOHNS, M. D. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Hemorrhage (Probably Pulmonary Tuberculosis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. J. Patterson, M. D. (Coroner)

4/18/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

UNDERTAKEE ADDRESS

508 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33017

## CERTIFICATE OF DEATH.

SEIFERT

E 33017

### 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital No. 37 St. 37 Ward 37)

### 2-FULL NAME

(a) RESIDENCE NO. Not known St. --- Ward ---

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. ---

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) June 6 1886

7 AGE Years 41 Months 10 Days 1 IF LESS than 1 day.....hrs. or.....min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country) Balto. Ind.

10 NAME OF FATHER Jacob Seifert

11 BIRTHPLACE OF FATHER (city or town).....  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna H. Denerow

13 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) Germany

14 Informant Gus Seifert (Brother)  
(Address) 1713 N. Wolfe St.

15 Filled..... 19.....  
1928 Registrar ---

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an.....  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....  
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) Ch. asthma

Apr 19/28 (duration) 6 wks yrs. mos. ds. ---  
(Address) 143 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.  
was disease contracted, if not at place of death!

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Not known Date of Burial Apr 24 1928

20 UNDERTAKER Lilly & Seiler Inc.

ADDRESS 1403 S. Wolfe St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33018

## CERTIFICATE OF DEATH.

31

E 33018

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital 3-4 St., 3-4 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurred life yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race C 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 18977 AGE Years 30 Months 4 Days 1 IF LESS than 1 day...hrs. or...min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Balt

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balt

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt

## PARENTS

14 Informant R. E. E. Jones  
(Address) 1400 E. Jones15 Filed 19 1928 J. H. JONES Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.)and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Inf. TB.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death...yrs....mos....ds. In the State...yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Asbury Cemetery Apr 19 1928

20 UNDERTAKER ADDRESS

George F. Ruth 1735 Bayford

B. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 19 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33019

1. PLACE OF DEATH

CITY OF BALTIMORE; (No. *418 N. Eden*)ST. *5-8*

WARD)

2. FULL NAME *Sarah Pratt*(a) RESIDENCE No. *418 N. Eden*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*female col widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *widowed*6 DATE OF BIRTH (month, day, and year) *April 4, 1850*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*78 — 13*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Domestic 070*

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

HARRISON JONES, R. L.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/17 28*

17

I HEREBY CERTIFY, That I attended deceased from

*4-8*, 19*28*, to *4-17*, 19*28*that I last saw her alive on *4-17*, 19*28*and that death occurred, on the date stated above, at *12:00* p.m.

The CAUSE OF DEATH\* was as follows:

*Apoplexy (Hemorrhage) Atherosclerosis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*John H. Owens**538 Delphi*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33020

## CERTIFICATE OF DEATH.

E 33020

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *West Bath Lane Box 28-65* Ward)

## 2-FULL NAME

*Ellen Eckert*

## (a) RESIDENCE NO.

*Ridgemoor Hillsdale*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *69* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 Color or Race

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Joseph Eckert*

6 DATE OF BIRTH (month, day, and year)

*1859*

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

*69*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

*Balto md April 19-25*

(State or country)

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town)

*md*

(State or country)

12 MAIDEN NAME OF MOTHER

*Ellen Fowler*

13 BIRTHPLACE OF MOTHER (city or town)

*md*

(State or country)

14

Informant (Address)

*Harry Eckert, Pikesville md*

15 Filed.....19

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192*8*17 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....*Inquest*..... (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said..... (Inquest, au-

topsy or inquiry.) and that said deceased came to..... death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*2 degree Burns.**(Accident)*

CONTRIBUTORY (Secondary)

(Signed).....*J. B. York*..... M. D.

(Coroner)

(Address) *Butler & Lincoln St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*Balto Co. St. James Len. April 21 1928*

20 UNDERTAKER

ADDRESS

*Wm C Brooks Sparks md*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## E 33021 CERTIFICATE OF DEATH.

90 E 33021

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 W. Levington ST. 19 WARD)

## 2-FULL NAME

Mary M. Deets

## (a) RESIDENCE NO.

1417 W. Levington ST. 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? 26 yrs. 6 mos. 0 ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wilton Deets

## 6 DATE OF BIRTH (month, day, and year)

May 3rd 1886

## 7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or .... min.

411114

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore County, Md.

## 10 NAME OF FATHER

Joseph O'Brien

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Elizabeth Gorsuch

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore County, Md.

## PARENTS

## 14

Informant (Address)

Elizabeth M. Moore  
1417 W. Levington St.

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 17 1928

## 17

I HEREBY CERTIFY, That I attended deceased from April 16, 1928, to April 17, 1928.that I last saw him alive on April 16, 1928, and that death occurred, on the date stated above, at 7:50 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease(duration) 1 yrs. — mos. — ds.

## CONTRIBUTORY (Secondary)

Cerebral Hemorrhage(duration) — yrs. — mos. 1 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

Clinical Findings(Signed) J. A. Bruchman, M. D., 19 (Address) 37 S. Sticker St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

NOVAL

DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

Western Cemetery  
403 W. Pratt, 1853 W. Balto St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 19 1928



Physician should state EXACTLY. PHYSICIAN should state EXACTLY. AGE should be stated EXACTLY. PHYSICIAN should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33022  
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 N. Lombard ST. 20-28 WARD)

2-FULL NAME Sophia C. Adams

(a) RESIDENCE NO. 930 N. Lombard ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Adams

6 DATE OF BIRTH (month, day, and year) April 4-1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md

10 NAME OF FATHER John Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14

Informant (Address)

15

Filed

1924 C. H. JONES, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18-1928

I HEREBY CERTIFY, That I attended deceased from Mar 18, 1928, to April 18, 1928, that I last saw her alive on April 12, 1928, and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma uterine.

(duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ☒ Date of ☒

Was there an autopsy? ☒

What test confirmed diagnosis? Clinical

(Signed) E. Kelly Hennessy, M. D.

4-19-1928 (Address) 2000 Halling St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 33023

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33023

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2124 Tule ST. W 28 WARD)2-FULL NAME Emma F. Burke(a) RESIDENCE NO. 2124 Tule ST. W 28 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick H. Burke6 DATE OF BIRTH (month, day, and year) Dec 15 1870

7 AGE

Years 57Months 4Days 3

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) =(c) Name of employer =9 BIRTHPLACE (city or town) (State or country) Charles County Md10 NAME OF FATHER John Goodrich11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles County Md12 MAIDEN NAME OF MOTHER Emily Smith13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles County Md

PARENTS

14 Informant Patrick H. Burke (Address) 2124 Tule St

15

Filed 5Registrar W. J. Jones

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1928

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1927, to Apr 18, 1928that I last saw her alive on Apr 17, 1928and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH\* was as follows:

Pulmonary TuberculosisCONTRIBUTORY (Secondary) Pulmonary(duration) yrs. 4 mos. 16 ds.(duration) yrs. 2 mos. 2 ds.18 Where was disease contracted if not at place of death? NoDid an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Specimen(Signed) J. H. K. K. K.19 Address 1729 N. E. St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL New CatholicDATE OF BURIAL Apr 19 192820 UNDERTAKER H. H. H. H.ADDRESS 1850 N. E. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33024

E 33024

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE:

(No. 619 N. Port St., 7-10 Ward)

## 2-FULL NAME

Josephine Charlotte Fluschnmann

(a) RESIDENCE NO.

619 N Port

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)Female White Married

5a If married, widowed, or divorced

~~HUSBAND~~

(or) WIFE of

Michael Fluschnmann

6 DATE OF BIRTH (month, day, and year)

Feb 20-1874

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.54129

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workHousework(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Ind

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

(Address)

Michael Fluschnmann  
619 N Port

15

Filed

1928

16

C. P. Jones, Jr.

Registrar

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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

17

I HEREBY CERTIFY, That I attended deceased from

4-14284-1828

that I last saw him alive on

4-1828and that death occurred, on the date stated above, at 3:10 H.m.

The CAUSE OF DEATH\* was as follows:

(Strangled) Umbilical  
Stoma

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Toxic absorption

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

no

Date of

Refused

Was there an autopsy?

no

What test confirmed diagnosis?

Signed

Edward Leok

M. D.

4/18/28

(Address)

415 N. Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

REMOVAL

Date of Burial

20 UNDERTAKER

John J. Herr

ADDRESS

156 N. Luzerne

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33025

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 5-8 WARD)2-FULL NAME Fred. E. Houseman(a) RESIDENCE NO. 11 W. Exeter ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 7 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) 77 AGE Years 71 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER John A. Houseman11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Mary Ann13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) Records

15

Filed 19 1928 JONES, M. D. RegistrarREGISTERED NO. E 33025

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12/1928

17

I HEREBY CERTIFY, That I attended deceased from July 4, 1928 to April 12, 1928 that I last saw him alive on April 12, 1928and that death occurred, on the date stated above, at 5:25 P. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis - chronic & acutearteriosclerosis(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted \_\_\_\_\_ if not at place of death? ?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? General & Sidel(Signed) E. J. Jones M. D.

, 19 \_\_\_\_\_ (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL General & SidelDATE OF BURIAL 4/14/2820 UNDERTAKER J. J. JonesADDRESS 1218 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.



E 33026

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33026

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balto City Hospital 5-8* WARD)2-FULL NAME *William Searcy*(a) RESIDENCE NO. *1031 Miller*(Usual place of abode)  
Length of residence in city or town where death occurred *40* yrs. mos. ds.

ST. WARD

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, Divorced (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary Searcy*6 DATE OF BIRTH (month, day, and year) *Mar 31 1857*7 AGE Years Months Days *72* If LESS than 1 day, hrs. or min. *16*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Labors*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Missouri*10 NAME OF FATHER *John Searcy*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ky*12 MAIDEN NAME OF MOTHER *Delia Hinson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va*14 Informant (Address) *Bay View Records Eastern Ave*15 *PR 19 1928* C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 17 1928*17 I HEREBY CERTIFY, That I attended deceased from *9-14* 19*27*, to *4-17* 19*28* that I last saw him alive on *4-17* 19*28* and that death occurred, on the date stated above, at *8:45* m.The CAUSE OF DEATH\* was as follows:  
*Carcinoma of prostate.*

(duration) yrs. 1 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Exam*(Signed) *W. Searcy* M.D.19 (Address) *Balto City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*St Pauls Parochians April 19 1928*

20 UNDERTAKER

ADDRESS

*Now Cook 512 E North*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33027

## CERTIFICATE OF DEATH.

44 ✓ E 33027

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 810 W. Lombard

St. 18-29 Ward)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincas Sayeuskas

(a) RESIDENCE NO. 810 W. Lombard

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 20 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1872

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

56

8 OCCUPATION OF DECEASED

Tailor

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Lithuania

(State or country)

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

PARENTS

14

Informant K. Traposka

(Address) 810 W. Lombard St.

15 Filed

APR 19 1926

16 HANSON JONES, H.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 17

1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry

and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cancer of the Stomach

(duration) yrs. mos. ds.

CONTRIBUTORS

(Secondary)

(Signature)

(Coroner)

4/19<sup>28</sup> (Address) 2739 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer

Apr 24 28

20 UNDERTAKER

ADDRESS

John G. Ribickas

423 S. paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Missing

#33028

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33029

E 33029

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Balto. General Hospital* - *WARD*)2-FULL NAME *Lois Smith*(a) RESIDENCE No. *124 Harlem Ave.* ST. *WARD*

(Usual place of abode)

Length of residence in city or town where death occurred *8* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

## REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *Colored*5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *October 14, 1903*

7 AGE

Years *24*Months *5*Days *5*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *North Carolina*10 NAME OF FATHER *Edward Smith*11 BIRTHPLACE OF FATHER (city or town) (State or country) *North Carolina*12 MAIDEN NAME OF MOTHER *Georgia Foster*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *North Carolina*14 Informant *Mary Carterfield* (Address) *1110. N. Lafayette*15 *1919* *1928* *C. HANSON JONES, M. D.* Registrar *R. H. H.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 19* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *April 14*, 19 *28*, to *April 19*, 19 *28*, that I last saw her alive on *April 19*, 19 *28*, and that death occurred, on the date stated above, at *7:10 A. M.*

The CAUSE OF DEATH\* was as follows:

*Vincent's Angina (Generalized)*(duration) yrs. *1* mos. *0* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. *0* mos. *0* ds.18 Where was disease contracted if not at place of death? *?*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis *Clinical, microscopic & autopsy*(Signed) *Karl Schenker* M. D.4-19-1928 (Address) *West Balto. General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*MOVAL* *M. Zion**Apr 20* 19 *28*

20 UNDERTAKER

ADDRESS

Registrar

*Wm. N. Chase* *1400 N. Chesapeake*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33030

## CERTIFICATE OF DEATH.

E 33030

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3322 E. Baltim ST. 9-47 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Summers(a) RESIDENCE No. 86137 Greenmount ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Widowed6a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Summers (deceased)

6 DATE OF BIRTH (month, day, and year)

7 AGE

60

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltim10 NAME OF FATHER John F. Bracken11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.12 MAIDEN NAME OF MOTHER Annie F. Jones13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltim

14

Informant (Address) Mrs. Frank Reynolds  
3322 E. Baltim St.

15

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17, 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 12, 1928 to Apr. 17, 1928, that I last saw her alive on Apr. 17, 1928 and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH\* was as follows:

Bronchial PneumoniaCONTRIBUTORY (duration) yrs. mos. ds. Cardiac dilatation(duration) yrs. mos. ds. 1218 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Examination(Signed) Berni S. Hayden M.D.4/18/1928 (Address) 1216 N. Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn

DATE OF BURIAL

April 20, 1928

20 UNDERTAKER

Frank V. Pipitone

ADDRESS

2518 E. Balt St

E 33031

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH *Union Memorial Hospital*CITY OF BALTIMORE: (No. *33rd + Calvert St. #33-47* ST., *47* WARD)2-FULL NAME *James Edwin Webster*(a) RESIDENCE NO. *Belair Md.* ST., \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred yrs. \_\_\_\_\_ mos. *6* ds. \_\_\_\_\_ How long in U. S., if of foreign birth? *Belair Md.* ds. \_\_\_\_\_  
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of *Dora C. Rouse*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Apr. 23, 1857*7 AGE Years *71* Months *71* Days *6* If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ or \_\_\_\_\_ min. *26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Lawyer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Belair, Md.*  
(State or country)10 NAME OF FATHER *Edwin J. Webster*11 BIRTHPLACE OF FATHER (city or town) *Churchville*  
(State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Caroline McCormick*13 BIRTHPLACE OF MOTHER (city or town) *Belair*  
(State or country) *Md.*14 Informant *Edwin H. Webster Jr.*  
(Address)15 Filed *1928* *19* *C. HANSEN JONES, M. D.*  
*RPH* RegistrarREGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 19, 1928*17 I HEREBY CERTIFY, That I attended deceased from *Apr. 13, 1928*, to *Apr. 19, 1928*,  
that I last saw him alive on *Apr. 19, 1928*and that death occurred, on the date stated above, at *4:45 p.m.*

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*  
*(Bilateral)*CONTRIBUTORY *Myocardial insufficiency*  
(Secondary) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *6* ds. \_\_\_\_\_18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Physical examination*(Signed) *Wallace Swartzwelder, M. D.*, 19 (Address) *Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Rock Spring, Md* DATE OF BURIAL *Apr 21 1928*20 UNDERTAKER *Dean & Foster, Bel Air, Md* ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33032

33032

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. *City Hospital* ST. *8-12* WARD)2. FULL NAME *Vincent Del Rosso*(a) RESIDENCE NO. *2424 E. Chase* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? *40* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *widowed*5a If married, widowed, or divorced HUSBAND of or WIFE of *Anna Del Rosso*6 DATE OF BIRTH (month, day, and year) *3 1857*7 AGE Years *66* Months *76* Days *1* If LESS than 1 day, hrs. *05* min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Italy*10 NAME OF FATHER *Vincent Del Rosso*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *Serena Iusini*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*14 Informant (Address) *Reverend*15 Filed *1029* 19 *C. HANSON JONES, M.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/17/ 1928*17 I HEREBY CERTIFY, That I attended deceased from *Apr. 11, 1928* to *Apr. 17, 1928*, that I last saw him on *Apr. 17, 1928*and that death occurred, on the date stated above, at *11:00 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*(duration) yrs. mos. *9* ds.CONTRIBUTORY (Secondary) *Myocarditis*

(duration) yrs. mos. ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *General & Sub*(Signed) *C. Vincent Jones, M. D.*

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Redeemer Ch.**4/19/28*

20 UNDERTAKER

ADDRESS

*D. George Ruth* *1735 Hayfield*

PHYSICIANS should state EXACTLY, Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 33033

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33033

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

3403 University Place 12-49

ST. WARD

## 2-FULL NAME

Brantly Foster Ingram

(a) RESIDENCE No.

3403 University Place

(Usual place of abode)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles Ingram

6 DATE OF BIRTH (month, day, and year)

July 17<sup>th</sup> 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

9

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Robert Edward Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Josephine Williamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Mrs Harvey F. Winickler 3403 University Place

15

1928

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 19<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 1<sup>st</sup>, 1928, to April 19<sup>th</sup> 1928, that I last saw her alive on April 18<sup>th</sup> 1928, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma. (Ovaries)

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. — ds.

Intestinal Obstruction

(duration) yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death?

✓

Did an operation precede death?

Yes

Date of

Feb. 4<sup>th</sup>

Was there an autopsy?

✓

What test confirmed diagnosis?

(Signed)

Robert L. Kerk, M. D.

Date

4/19, 1928

(Address)

3126 Hartford Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmount Cemetery

April 21<sup>st</sup> 1928

20 UNDERTAKER

ADDRESS

1723 N. Lloyd St



33034

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33034

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2126 N. Smallwood ST. 15-60 WARD)2-FULL NAME Charles L. Anderson(a) RESIDENCE. No. 2126 N. Smallwood ST. WARD.(Usual place of abode)  
Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Edith M. Anderson6 DATE OF BIRTH (month, day, and year) May 28, 18697 AGE Years 58 Months 10 Days 21 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None9 BIRTHPLACE (city or town) Deal's Island  
(State or country) Somerset County, Md.10 NAME OF FATHER Levin L. Anderson11 BIRTHPLACE OF FATHER (city or town) Deal's Island  
(State or country) Md.12 MAIDEN NAME OF MOTHER Margaret Daniels13 BIRTHPLACE OF MOTHER (city or town) Deal's Island  
(State or country) Md.14 Informant Edith M. Anderson  
(Address) 2126 N. Smallwood St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 192817 I HEREBY CERTIFY, That I attended deceased from March 19, 1927, to April 16, 1928, that I last saw him alive on April 16, 1928, and that death occurred, on the date stated above, at 8:17 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease(duration) 3 yrs. — mos. — ds.CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Quinn, M. D.Address 1507 N. Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Lorraine Cemetery4/21/28

## 20 UNDERTAKER

## ADDRESS

Chas. F. Evans & Son 118 N. Mt. Royal

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

APR 19 1928

ROBERT J. JONES, M. D., Registrar

E 33035

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33035

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital*)

## 2-FULL NAME

*James Richardson*(a) RESIDENCE NO. *1246 N. Gay*

(Usual place of abode)

Length of residence in city or town where death occurred *Lifetime*

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan 27-1928*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*3 22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto. Md.*

10 NAME OF FATHER

*Jos. V. Richardson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto. Md.*

12 MAIDEN NAME OF MOTHER

*Minnie Williams*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto. Md.*

14

Informant (Address)

*Minnie Richardson 1246 N. Gay St.*

15

Filed

19

*C. HANSEN JONES, M. Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/12/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *4/16/28*, 19, to *4/18/28*, 19,that I last saw him live on *4/17/28*, 19,and that death occurred, on the date stated above, at *3:45 A* m.

The CAUSE OF DEATH\* was as follows:

*chronic pneumonia*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*cardiac degeneration*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Laurence Fabian*, M. D., 19 (Address) *St. Joseph's Hospital.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Baltimore Cemetery*

DATE OF BURIAL

*4/21/28*

20 UNDERTAKER

*Charles S. Tracey 118 W. Mt. Royal Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33036

E 33036

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.,

WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

17 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

62 Years  
63

Months

89

Days

17

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Teacher

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Philadelphia Pa.

10 NAME OF FATHER

Mark Conliff

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

England

12 MAIDEN NAME OF MOTHER

Catherine McQuaid

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Pa.

14

Informant

(Address)

Dr. D. G. Wilson  
210 E. Preston St.

15 1928

G. HANCOCK JONES, M. D.  
Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 6, 1928, to April 18, 1928,

that I last saw her alive on April 18, 1928,

and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH\* was as follows:

Fracture of neck of femur

18 (duration) yrs. 2 mos. 5 ds.

19 (duration) yrs. — mos. 3 ds.

20 Where disease contracted  
If not at place of death? 210 E. Preston St

Did an operation precede death? Yes Date of Feb 6, 1928

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. M. M. D.

19 (Address) Woman's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Locust Grove Cemy, Annapolis April 20, 1928

20 UNDERTAKER

ADDRESS

J. H. Mitchell &amp; Sons 1900 E. Pratt St

CAUTION—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33037

33037

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Harvard C. Kelly Hospital* 48

CITY OF BALTIMORE: (No. ST. 14-76 WARD 10)

2-FULL NAME *Miss M. Corinne Dana*(a) RESIDENCE No. *1418 Eutaw Place*

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *6* mos.

ST. WARD

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April, 15, 1885*7 AGE Years *73* Months *—* Days *1* If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Mass*10 NAME OF FATHER *Joshua C. Dana*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Mass*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Mass*14 Informant *Miss Kathryn Elliott* (Address) *1609 Eutaw Place*15 Filed *C. HANFORD JONES, M. D.* Registrar *R.H.*

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April, 19, 1928*17 I HEREBY CERTIFY, That I attended deceased from *Dec. 19, 1921* to *April 19, 1928*, that I last saw her alive on *April 19, 1928*, and that death occurred, on the date stated above, at *5:30 P.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Face*(duration) *23* yrs. mos. ds.CONTRIBUTORY *Cerebral Hemorrhage* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Mass.*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Tissue Section*(Signed) *Edward Kelly* M. D., 19 (Address) *1418 Eutaw Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Boston Mass**April 20, 1928*

20 UNDERTAKER

ADDRESS

*Chas. G. Black 742 W North Ave*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

19-1928



E 33038

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33038

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 602 S. 12<sup>th</sup> St, 26-37 Ward)

2-FULL NAME Marie E Hoopes

(a) RESIDENCE NO. 602 S 12<sup>th</sup> St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day..... hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filed

R 19 1928

C. HARRISON JONES, M. D. Registrar

Per

R. P. B.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1928

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1927, to Apr 18, 1928

that I last saw her alive on Apr 17, 1928

and that death occurred, on the date stated above, at 5<sup>26</sup> 4 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Breast &amp; metastasis

CONTRIBUTORY

(Secondary)

Breast

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of Oct 1927

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Exam

(Signed) C. Harrison Jones, M. D.

1928 (Address) 2439 Eastern Ave

\*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Unity Cemetery

April 20, 1928

20 UNDERTAKER

Wendell Dippel, Son 37 &amp; am

PHYSICIANS should state  
Exact statement of OCCUPA-  
TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 33039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 33039  
REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1124 Ave. West* ST. *10-71* WARD)

2-FULL NAME

*George Jones*

(a) RESIDENCE NO.

*3817 Monastery Ave*

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *59* yrs. *7* mos. *23* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

*Mrs. Louise M. McKelvie*

6 DATE OF BIRTH (month, day, and year) *Aug 26<sup>th</sup> 1869*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*59* *7* *23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Inspector*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

*Ind. Md. Young*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

*Ind. Md.*

12 MAIDEN NAME OF MOTHER *Mary West*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

*Ind. Md.*

14 Informant *Mrs. Loe. Young*  
(Address) *3817 Monastery Ave*

*PR 20 1928*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 19 1928*

17 I HEREBY CERTIFY, That I attended deceased from *4-1-28* 1928 to *April 19* 1928, that I last saw him alive on *April 19* 1928 and that death occurred, on the date stated above, at *12<sup>45</sup> a.m.*

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*

CONTRIBUTORY *Laryngotomy for*  
*Carcinoma* (duration) yrs. mos. ds. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *4/5/28*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Francis L. Sabapheera* M. D.

19 (Address) *1124 Ave. West*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*National Cem.*

20 UNDERTAKER

*John Bowman*

DATE OF BURIAL

*Apr 23<sup>rd</sup> 1928*

ADDRESS

*1124 Ave. West*

E 33040

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33040

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *913 Hollins*)2-FULL NAME *James O. Buddy*(a) RESIDENCE NO. *913 Hollins*  
(Usual place of abode)Length of residence in city or town where death occurred *40* yrs. mos. ds.ST. *18-29* WARDREGISTERED NO. *90*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male. White.**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 11 1868*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*60**1**17*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*(b) General nature of industry, business, or establishment in which employed (or employer) *Self-employed*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *James O. Buddy*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Ellen Rugg*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*14 Informant *Miss Mary Hickey*  
(Address) *913 Hollins St.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 18 1928*

17

I HEREBY CERTIFY, That I attended deceased from *4/17*, 19 *28*, to *4/18*, 19 *28*.that I last saw him alive on *4/17*, 19 *28*.and that death occurred, on the date stated above, at *5:15 A. M.*

The CAUSE OF DEATH\* was as follows:

*Int. Schism  
Myocarditis*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *James J. Jones*, M. D.(Address) *910 W. 1st St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 20 1928

Filed

HARRISON JONES, M. D.

Registrar

*John J. Brown & Son**Apr 21 1928**901 Hollins St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33041

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD \_\_\_\_\_)

2-FULL NAME *Margaret Coker*(a) RESIDENCE No. *624 S. 18th*

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced (or) WIFE of *Geo. D. Coker*6 DATE OF BIRTH (month, day, and year) *Nov 12 - 1882*7 AGE Years *45* Months *5* Days *4* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Ind.*10 NAME OF FATHER *Pat Moran*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Ind.*12 MAIDEN NAME OF MOTHER *Catherine Callery*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Ind.*14 Informant (Address) *Records*15 Filled by *E. H. Jones, M. D.* Registrar*Coker*129 ✓  
E 33041

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

*16-37*

ST. \_\_\_\_\_ WARD \_\_\_\_\_

ST. \_\_\_\_\_ WARD \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/16/1928*17 I HEREBY CERTIFY, That I attended deceased from *Apr 10, 1928* to *Apr 16, 1928* that I last saw her live on *Apr 16, 1928* and that death occurred, on the date stated above, at *3:00 P. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic interstitial nephritis  
Hypertension*(duration) \_\_\_\_\_ yrs. *6* mos. ds.CONTRIBUTORY (Secondary) *Myocarditis**Chronic* (duration) \_\_\_\_\_ yrs. mos. ds.18 Where was disease contracted? *?* if not at place of death?Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Cervical & Sub.*(Signed) *C. J. Jones, M. D.*

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

*Cath. Lawn Cemetery 4/20/28*  
*J. J. Moran* ADDRESS *3000 E. Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 20 1928



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33042

CERTIFICATE OF DEATH

129✓  
E 33042  
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1811 W. Baltimore St. 19-28 Ward)

2-FULL NAME John B. Kuhl

(a) RESIDENCE NO. 1811 W Baltimore St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Late Estella Kuhl

6 DATE OF BIRTH (month, day, and year) ? ? 1859

7 AGE Years Months Days IF LESS than 1 day hrs. or min.. 69

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

10 NAME OF FATHER Gottlieb Kuhl

11 BIRTHPLACE OF FATHER (City or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Shilling

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)

14 Informant Mr. Joseph Muth  
(Address) 1811 W Baltimore St.

15 Filed 1928 19-28 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 28 April 18 18

17 I HEREBY CERTIFY, That I attended deceased from Jan 1928, to April 18 1928

that I last saw ~~him~~ alive on April 18 1928

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic hepatitis

(duration) 1 yrs. - mos. - ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? biopsy

(Signed) R. J. M. M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

Date of Burial

April 28

20 UNDERTAKER

Harry H. Witke

ADDRESS

10-31 W. Lombard St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33043

## CERTIFICATE OF DEATH

98 E 33043

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* 3-4 Ward)2-FULL NAME *Lewis Gambel*(a) RESIDENCE NO. *1627 E. Lombard St.* Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced. (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *4/24/28*7 AGE Years *5* Months *1* Days *28* IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md*  
(State or country)10 NAME OF FATHER *Isaac Gambel*11 BIRTHPLACE OF FATHER (City or town) *Russia*  
(State or country)12 MAIDEN NAME OF MOTHER *Rose Rubin*13 BIRTHPLACE OF MOTHER (city or town) *Russia*  
(State or country)14 Informant *Isaac Gambel*  
(Address) *1627 E Lombard St*15 Filed *APR 20 1928* 19 *11:00 AM* JONES, H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/19/28* 1917 I HEREBY CERTIFY, That I attended deceased from *11/23/28*, 19, to *4/19/28*, 19, that I last saw him alive on *4/19/28*, 19, and that death occurred, on the date stated above, at *4 P M*.

The CAUSE OF DEATH\* was as follows:

*acute cardiac dilatation*  
(duration) *5* yrs. mos. ds.  
CONTRIBUTORY *old structure of*  
(Secondary) *larynx & trachea*  
(duration) *3* yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *Urinal*  
(Signed) *J. S. W. M. D.*  
19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Hebrew Cemetery* *4/20 1928*  
20 UNDERTAKER *Jack Lewis 1439 E. 34th St*  
ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33044

## CERTIFICATE OF DEATH.

E 33044

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3300 E. Rogers ST., 127-55 WARD)

2. FULL NAME Mary Myerberg

(a) RESIDENCE NO. 3300 E. Rogers ST., 127 WARD 27

(Usual place of abode)  
Length of residence in city or town where death occurred 3 yrs. 7 mos.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 41 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced, HUSBAND of or WIFE of Abraham Myerberg

6 DATE OF BIRTH (month, day, and year) April 20, 1862

7 AGE 65 Years 6 Months 28 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Warsaw (State or country)

10 NAME OF FATHER Paland Victor Buech

11 BIRTHPLACE OF FATHER (city or town) Paland (State or country)

12 MAIDEN NAME OF MOTHER Rosa Harris

13 BIRTHPLACE OF MOTHER (city or town) Paland (State or country)

14 Informant, (Address) Beatrice Marbury 3300 E. Rogers St.

15 Filed C. HARRISON JONES, M. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1928

17 I HEREBY CERTIFY, That I attended deceased from Mar. 31, 1928, to April 18, 1928, that I last saw her alive on April 18, 1928, and that death occurred, on the date stated above, at 6:20 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia 3 weeks

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 1/2 ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? chest

(Signed) Herman R. Davis, M. D.

(Address) 2601 Manhattan Av.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

Hebrew Mass Hool

20 UNDERTAKER

Jack Lewis 1439 E. Pratt St.

DATE OF BURIAL

4/20 1928

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 20 1928

E 33045 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33045

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital,

CITY OF BALTIMORE: (No. Remington Avenue

2-FULL NAME Aiden Francis Bennett

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 800 S. Broadway  
(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 4 yrs. 6 mos.

ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1, 1898

7 AGE Years Months Days 29 29 11 18 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. H.H. Rogers

9 BIRTHPLACE (city or town) Dublin  
(State or country) Ireland

10 NAME OF FATHER William Bennett

11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)

12 MAIDEN NAME OF MOTHER Mary Mann

13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)14 Informant Records of U.S. Marine Hospital  
(Address)

15 Filed 20-1928 G. H. JONES, H. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 19 28

17

I HEREBY CERTIFY, That I attended deceased from January 27, 19 27, to April 17, 19 28,

that I last saw him alive on April 17, 19 28,

and that death occurred, on the date stated above, at 7:35 P.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis, pulmonary, chronic, active  
Tuberculous enteritis

(duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted,  
if not at place of death? Unknown

Did an operation precede death? yes Date of 2-9-28

Was there an autopsy? No

What test confirmed diagnosis? Sputum examinations  
and examination at operation

(Signed) J. J. Hall M. D.

19 (Address) U.S. Marine Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Marys Cemetery

April 20 19 28

20 UNDERTAKER

ADDRESS

E. L. Roy Stipples

1252 North Ave



E 33046

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

108 E 33046

## PLACE OF DEATH

CITY OF BALTIMORE (No. 1007 S Potomac

2-FULL NAME Andrew Wagner

(Residence in Baltimore: No. 1007 S Potomac

ST. 171 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 3 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Child (Write the word.)

6-DATE OF BIRTH, Oct 10, 1927 (Month) (Day) (Year)

7-AGE, 6 yrs. 10 mos. 10 da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, John Wagner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary Kwasna

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Wagner

(Address) 1007 S Potomac St.

15- Filed 20 1928 C. HARRISON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 1928 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Microscopic Examination

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 2 hours

(Signed) M. D.

(Coroner.) 143 W. 191 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, St Stanislaus Cem April 20, 1928

20-UNDERTAKER, ADDRESS, Stephen J. Galkowski 1800 Glenwood Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33047

## CERTIFICATE OF DEATH.

90 E 33047

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1337 N. Stockton 5-23 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1337 N. Stockton Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

Cauc

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

1886

7 AGE

42

41

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Housework

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

H. A. Co. Md.

(State or country)

10 NAME OF FATHER

Jas. Whittington

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

H. A. Co. Md.

12 MAIDEN NAME OF MOTHER

Nancy Freeman

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

H. A. Co. Md.

14

Informant  
(Address)E. J. Forester  
1337 N. Stockton

15

Filed

APR 20 1928

H. A. Co. Md.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) one yrs. — mos. — ds.

CONTRIBUTORY  
(Secondary)

(duration) one yrs. — mos. — ds.

(Signed)

F. B. Lusk M. D.

Coroner

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Mt. Auburn Cemetery

April 20 1928

20 UNDERTAKER

Thomas E. Nelson

ADDRESS

1308 Madison St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 33048

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74-004 E 33048

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3403 Harford Ave. 8-4-5 ST. WARD)

2-FULL NAME George H. Dean

(a) RESIDENCE No. 3403 Harford ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Era Phelps

6 DATE OF BIRTH (month, day, and year) Dec 29 1875

7 AGE Years 52 Months 3 Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER James Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dorroughly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Era Dean (Address) 3403 Harford Ave.

15 Filed APR 20 1928 G. HARRISON JONES, Jr. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1928

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1928, to April 18, 1928, that I last saw him alive on April 18, 1928, and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Central Hemiplegia

CONTRIBUTORY (Secondary) (duration) 4 yrs. mos. ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) M. D.

(Address) 1907 N. Mount St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL Woodlawn Cemetery DATE OF BURIAL Apr 21 1928

20 UNDERTAKER John Uelrich ADDRESS 2008 Blenheim St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33049

E 33049

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Lemmon

2-FULL NAME Vedral M. Scott

(a) RESIDENCE No. 923 Lemmon

(Usual place of abode)

Length of residence in city or town where death occurred Life mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD (If non-resident give city or town and State) yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June, 22 1911

7 AGE Years Months Days 16 9 31 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Maryland (State or country)

10 NAME OF FATHER Frank Scott

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Lillian Whiteford

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Maryland (State or country)

14 Informant Mrs. Lillian Scott (Address) 923 Lemmon Street

15 JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 19 28

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1928, to Apr. 19, 1928, that I last saw her alive on Apr. 19, 1928, and that death occurred, on the date stated above, at 2.15 P. m. The CAUSE OF DEATH\* was as follows:

Chronic Int. Nephritis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL Loudon Park Cem.

UNDERTAKER

ADDRESS

1003 N. Bates



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33050

E 33050

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 E. Eager

ST. 10-14 WARD)

2-FULL NAME Annie M. Fahey

(a) RESIDENCE No. 708 E. Eager

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ST. WARD

ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

January 5, 1888

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

40

3

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Maryland

10 NAME OF FATHER

John J. Fahey

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER Mary B. Hunt

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Baltimore  
Maryland

14

Informant  
(Address)Mrs. Louis F. DeWoll  
708 E. Eager St.

15

Filed

PR 20 1928

JAN 20 1928

Per

R. H. Jones

Resident

UNDERTAKER

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

New Cathedral Cemetery

DATE OF BURIAL

Apr. 21 1928

ADDRESS

1003 West  
Baltimore St.

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mr. 1927 to April 18 1928

that I last saw him alive on April 18 1928

and that death occurred, on the date stated above, at 3:35 P. m.

The CAUSE OF DEATH\* was as follows:

General wasting & cessation of all  
body functions due to inability to  
swallow food, caused by Throat  
cancer & meningitis 20 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

S. S. Kover M. D.

516 Cathedral St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

New Cathedral Cemetery

DATE OF BURIAL

Apr. 21 1928

ADDRESS

1003 West  
Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Lexington Ave St. 174 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Davis6 DATE OF BIRTH (month, day, and year) 18827 AGE Years 46 Months — Days — IF LESS than 1 day...hrs. or...min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) N. C.10 NAME OF FATHER H. Smith11 BIRTHPLACE OF FATHER (city or town) N. C.  
(State or country)12 MAIDEN NAME OF MOTHER —13 BIRTHPLACE OF MOTHER (city or town) —  
(State or country)

## PARENTS

14 Informant Mr S. Davis  
(Address) 5-5-2 Munson St15 Filed APR 23 1928 19 C. H. Jones Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 28 19217 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest  
(Inquest, autopsy or inquiry) and that said deceased came to an death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Coronary ArteriosclerosisIndur (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Pulmonary Extension (duration) yrs. mos. ds.  
(Signed) M. D.(Address) 149 W. 2nd St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) from nursing home

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Ambrose Date of Burial 4/20/28UNDERTAKER Samuel H. HunsleyADDRESS 123 St. Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 33052

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33052

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *114 E. Cross*)ST. *24-33* WARD2-FULL NAME *Armie T Jones*(a) RESIDENCE NO. *114 E Cross*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Female White Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*J. Burkley Jones Jr*

6 DATE OF BIRTH (month, day, and year)

*JUNE 23/1873*

7 AGE

Years

Months

Days

ft LESS than

1 day, hrs

or min.

*54**9**27*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Housework*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*

10 NAME OF FATHER

*William H. Bowen*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Baltimore Md*

12 MAIDEN NAME OF MOTHER

*Margaret B Butler*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Ireland*

14

Informant  
(Address)*J. D. Burkley Jones Jr*  
*114 E Cross St*

APR 20 1928

HARRISON JONES, JR.  
Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 17 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Mar 24*, 19*28*, to *Apr 17*, 19*28*.that I last saw him alive on *Apr 17*, 19*28*,  
and that death occurred, on the date stated above, at *6:30 A* m.

The CAUSE OF DEATH\* was as follows:

*pernicious following  
chronic Int. suppurative  
menia 2 days*(duration) *3* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Wm. L. Stiles*, M. D.  
*4/9 1928* (Address) *139 E High St*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*London Park**April 20, 28*

UNDERTAKER

ADDRESS

*John F. Denny**715 Light St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33053

CERTIFICATE OF DEATH.

196 E 33053

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital, Ward 27-41)

2-FULL NAME William E. Koehne Jr.

(a) RESIDENCE NO. 4601 Asbury Ave.

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred 19 yrs. 8 mos. 6 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male.

White

Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

January 12, 1909.

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

19

3

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Lock Insulator Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

10 NAME OF FATHER

William E. Koehne Sr.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Matilda Mayers.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant John W. Koehne. (brother)  
(Address) 3503 Edgemere Ave.

15 Filed..... 19

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 18, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:  
Accidentally Electrocuted.  
While testing Insulators.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. .... mos. .... ds.  
(Signed) Wm. R. Pennington M. D.  
(Coroner)

4/20 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?  
Lock Insulator Co. Light & Cronwell etc

Former or usual residence April 18, 1928.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Baltimore Cemetery 4/21 1928

20 UNDERTAKER

Albert L. Nitz 1606 N. Chestnut



## E 33054 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Monroe ST. 16-22 WARD)2-FULL NAME Henry E. Snyder(a) RESIDENCE NO. 808 N. Monroe  
(Usual place of abode)Length of residence in city or town where death occurred 56 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO. E 33054  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Caroline Snyder  
(or) WIFE of Caroline Snyder6 DATE OF BIRTH (month, day, and year) Jan 22/727 AGE Years 56 Months 2 Days 27 LESS than 1 day, hrs. or min.8 OCCUPATION OF DECEASED Shipping Clerk  
(a) Trade, profession or particular kind of work China + Crockery

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hoos Co.9 BIRTHPLACE (city or town) Baltimore Md  
(State or country)10 NAME OF FATHER Louis Snyder11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Augusta Neff13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Caroline Snyder  
(Address) 808 N. Monroe St.15 Filed APR 20 1928 Registrar W. H. Jones, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 192817 I HEREBY CERTIFY, That I attended deceased from Mar 30, 1928, to Apr 18, 1928, that I last saw him alive on Apr 18, 1928, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

left side hemiplegia  
cerebral thrombosisCONTRIBUTORY (Secondary) 2nd hemorrhage  
(duration) yrs. mos. 20 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? usual tests(Signed) H. E. Knapp, M. D.(Address) 4025 Calver Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Lorraine

DATE OF BURIAL

20 UNDERTAKER Philip HenryADDRESS 2016Aileans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33055

## CERTIFICATE OF DEATH.

E 33055

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N. AnnST. 6-9 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Baby Jackson(a) RESIDENCE. No. 418 N. Ann

(Usual place of abode)

ST. 6-9 WARD.

Length of residence in city or town where death occurred

0 yrs.

0 mos.

0 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none6 DATE OF BIRTH (month, day, and year) Apr 19 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or 30 min.

0

0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Ind.10 NAME OF FATHER Wm. Jackson11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.12 MAIDEN NAME OF MOTHER Julia Gooden13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14

Informant (Address) 418 N. Ann St.

15

Filed

APR 20 1928

H. P. CO. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 19 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 19 1928, to Apr. 19 1928;that I last saw him alive on Apr. 19 1928,and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Newton, M. D.19 (Address) 1730 Linden av

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

at Bury cemeteryApr 20 1928

20 UNDERTAKER

ADDRESS 1631Edward Baysonorleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33056

## CERTIFICATE OF DEATH

+ 23E 33056

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. *Mercy Hospital* St., *4-7* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Marilyn Cohen*(a) RESIDENCE NO. *Roanoke, Virginia* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. / ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

*Female White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Aug 4-1927*

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

*1 11 15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Nurse*

9 BIRTHPLACE (city or town)

(State or country)

*Roanoke**Virginia*

10 NAME OF FATHER

*J. B. Cohen*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore Md*

12 MAIDEN NAME OF MOTHER

*Anna Gordon*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore Md*

14

Informant (Address)

*J. B. Cohen*

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/19/28*

17

I HEREBY CERTIFY, That I attended deceased from

*3/24/28*, 19\_\_\_\_, to *4/19/28*, 19\_\_\_\_,that I last saw her alive on *4/19/28*, 19\_\_\_\_,and that death occurred, on the date stated above, at *9:30* a.m.

The CAUSE OF DEATH\* was as follows:

*Encephalitis Lethargica*(duration) \_\_\_\_\_ yrs. *1* mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

*Myocardial Failure*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? *Clinical*

(Signed)

*J. B. Winstead*, M. D.

, 19

(Address)

*Mercy Hospital*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION or REMOVAL

Date of Burial

*Roanoke Va**April 20 1928*

20 UNDERTAKER

ADDRESS

*Wm. J. L. L. L.**None*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 33057

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44 E 33057

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Park Ave. 14-70 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Steptoe Duer

(a) RESIDENCE NO. 1401 Park Ave.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Rina Duer

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1877

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

50 6 29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Gloucester Co., Va.

10 NAME OF FATHER Rufus A. Duer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Somerset Co., Md.

12 MAIDEN NAME OF MOTHER Elmira Fitzhugh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Middlesex Co., Va.

14

Informant

(Address)

Wife - Rina Duer  
1401 Park Ave.

15

Filed

1920

139

G. H. HARRIS

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Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 25, 1928, to April 18, 1928,

that I last saw him alive on April 18, 1928,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH\* was as follows:

Carcinomatous metastases  
to liver, probably secondary  
to colon (duration) yrs. 6 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) R. E. Horman, M. D.

4-18-1928 (Address) 1101 St. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Urbana, Va.

DATE OF BURIAL

4/21 1928

20 UNDERTAKER

W. J. Dickens Sons

ADDRESS

La No



E 33058

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33058

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Md Emmuel &amp; Josephine

REGISTERED NO.

City of BALTIMORE: (No.

Madison &amp; Kearsney

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Miles

(a) RESIDENCE NO.

Laurie Md

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

1

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 6, 1858

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

69

6

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Self

(c) Name of employer

Self

9 BIRTHPLACE (city or town)

(State or country)

Laurie Md

10 NAME OF FATHER

Thos Miles

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Howard Co Md

12 MAIDEN NAME OF MOTHER

Cecilia White

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Howard Co Md

14

Informant (Address)

Hospital Room

15 Filed

19

C. H. HARRISON Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-19-28

17

I HEREBY CERTIFY, That I attended deceased from

4-18-28

19

to 4-19-28

19

that I last saw him alive on

4-19-28

19

and that death occurred, on the date stated above, at

6 P. m.

The CAUSE OF DEATH\* was as follows:

Intestinal Obstruction

(duration)

5 ds.

CONTRIBUTORY

(Secondary)

Uremia &amp; edema

(duration)

yrs.

mos.

2

ds.

18 Where was disease contracted

if not at place of death

Laurie Md

Did an operation precede death?

Date of

4-18-28

Was there an autopsy?

No

What test confirmed diagnosis?

Urinalysis

(Signed)

19

(Address)

J. H. Thompson, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Laurie Md.

4/22/28

20 UNDERTAKER

ADDRESS

Lloyd Turner

Laurie Md

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 33059

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 Frederick ST. 15-21 WARD)

## 2-FULL NAME

Arnie Mary Herman(a) RESIDENCE NO. 1600 Frederick ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William Herman6 DATE OF BIRTH (month, day, and year) Dec 18-1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

534—

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

William P. Gentry

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Mary Susan Gentry

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Mr. Ben D. Gentry  
1600 Frederick St

15

Filed

19

G. H. Gentry  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 19 28

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1926, to April 18, 1928, that I last saw him alive on April 18, 1928, and that death occurred, on the date stated above, at 12:30 a.m. The CAUSE OF DEATH\* was as follows:Chronic interstitial nephritis(duration) one yr. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. one ds.18 Where was disease contracted if not at place of death? Place of workDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical & chemical analysis  
(Signed) Wm. Gentry, M. D.4/19, 1928 (Address) 1701 E. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Louison Park Bur  
Narry W. GentryApr 21 1928  
1948 North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33060

## CERTIFICATE OF DEATH.

90 E 33060

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 849 Boyd St. 18-29 Ward)

2-FULL NAME Anna Elizabeth Nelson

(a) RESIDENCE NO. 849 Boyd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female Negro Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year)  
18657 AGE Years Months Days IF LESS than  
63 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....Housework(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....  
(State or country) Balto. Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town).....  
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) Unknown14 Informant Annie Rome  
(Address) 430 N. Dallas St.15 Filed..... 19 C. H. Jones, M.  
APR 20 1928 Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 April 16

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-  
topsy or inquiry.)inquiry find that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocardial  
Insufficiency

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)(Signed) Eugene J. Zeller M. D.  
(Coroner)

4/19/19 28 Address 2739 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL Mt. Auburn Cem. Oct. 20 1928

20 UNDERTAKER

ADDRESS

Christ N. Johnson 416 N. Caroline St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE  
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is  
very important. See instructions on back of certificate.

E 33061

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST. *15-68* WARD)2-FULL NAME *Miss Anna Eder*(a) RESIDENCE NO. *27 20 Baker* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 3, 1888*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*39 39 7 15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*10 NAME OF FATHER *Jacob Eder*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Kunigunda*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Germany*14 Informant *Mrs. L. J. Bruchey*  
(Address) *2720 Baker St.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/18/28*17 I HEREBY CERTIFY, That I attended deceased from *4/15/28*, 19 *28*, to *4/18/28*, 19 *28*, that I last saw her alive on *4/18/28*, 19and that death occurred, on the date stated above, at *4:25 a.m.*

The CAUSE OF DEATH\* was as follows:

*Acute Appendicitis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Acute dilatation of stomach* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *5/15/28*Was there an autopsy? *no*What test confirmed diagnosis? *Signatures & signs*(Signed) *J. H. O'Donnell*, M. D., 19 (Address) *St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery**4/21/28*

20 UNDERTAKER

ADDRESS

*Richard W. Meyer Ashburton St.*

APR 20 1928

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33062

## CERTIFICATE OF DEATH.

E 33062

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. *827 Harlem Ave* ST. *17-76* WARD)2. FULL NAME *Dessie D Torsch*(a) RESIDENCE NO. *827 Harlem Ave* ST. *17-76* WARDLength of residence in city or town where death occurred *45* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *M*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Edward L Torsch*6 DATE OF BIRTH (month, day, and year) *Mar. 25, 1851*

7 AGE

Years *77*Months *0*Days *24*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Va*10 NAME OF FATHER *Tripplett Douglas*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va*

14

Informant (Address) *Edward L Torsch*  
*827 Harlem Ave*

15

Filed *APR 20 1928*

19

U. S. DEPT. OF HEALTH

BUREAU OF VITAL STATISTICS

WASHINGTON, D. C.

1928

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Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 19 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Several years*, 19 *1928*, to *April 18, 1928*, that I last saw him alive on *April 18, 1928*, and that death occurred, on the date stated above, at *7\** m. The CAUSE OF DEATH\* was as follows:*Bronchitis**Several months*  
(duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *Organic Heart Disease*  
*Several years*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Henry M. Bayley M. D.**Apr 20 1928* (Address) *2805 N. Calvert St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *London Park*DATE OF BURIAL *Apr 21 1928*20 UNDERTAKER *J. M. Cook*ADDRESS *512 E. North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26-A Co.-200 Bks.

E 33063

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

E 33063

1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital*)

2-FULL NAME *Mary Blundean Witter*

(a) RESIDENCE NO. *4019 Eierman Ave.* St. *Belair Rd.* Ward

Length of residence in city or town where death occurred *5* yrs. *0* mos. *0* ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 21, 1921*

7 AGE Years *6* Months *11* Days *18* IF LESS than 1 day hrs. or min. *16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School Girl*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.*  
(State or country)

10 NAME OF FATHER *George W. Witter*

11 BIRTHPLACE OF FATHER (City or town) *Baltimore Md.*  
(State or country)

12 MAIDEN NAME OF MOTHER *Ida A. Heibel*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md.*  
(State or country)

14 Informant *Ida W. Witter*  
(Address) *4019 Eierman Ave.*

15 Filed *APR 20 1928* 19 *1928* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/19/28* 19

17 I HEREBY CERTIFY, That I attended deceased from *4/17/28*, 19, to *4/19/28*, 19,

that I last saw her alive on *4/19/28*, 19, and that death occurred, on the date stated above, at *11:56 a.m.*

The CAUSE OF DEATH\* was as follows:

*Septic meningitis*

(duration) yrs. mos. *4* ds.  
CONTRIBUTORY *Broncho pneumonia*  
(Secondary)

(duration) yrs. mos. *2* ds.

18 Where was disease contracted

if not at place of death? *2*

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Clinical*

(Signed) *J. W. Witter* M. D.

, 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Baltimore*

20 UNDERTAKER *W. C. Cook*

Date of Burial

*Apr 23 1928*  
ADDRESS *500 E. North Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33064

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *406 E 20th* ST. *12-19* WARD)2-FULL NAME *Mellie E. Dowell*(a) RESIDENCE No. *406 E 20th*

(Usual place of abode)

Length of residence in city or town where death occurred *48* yrs. mos.

ST., WARD

REGISTERED NO. *E 33064*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *M* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Samuel J. Dowell*6 DATE OF BIRTH (month, day, and year) *Aug. 20. 1860*7 AGE Years *67* Months *8* Days *29* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md*10 NAME OF FATHER *Elior Parks*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*12 MAIDEN NAME OF MOTHER *Ruth Anderson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*14 Informant (Address) *Samuel J. Dowell 406 E 20th St*15 Filed *APR 20 1928* 19 *1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 19 1928*17 I HEREBY CERTIFY, That I attended deceased from *Mich 12, 1928* to *Apr 18, 1928*, that I last saw her alive on *Apr 18, 1928*, and that death occurred, on the date stated above, at *2.45 a.m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Angina Pectoris*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No.* Date ofWas there an autopsy? *No.*

What test confirmed diagnosis?

(Signed) *Hugh Forsythe*, M. D.19, 1928 (Address) *424 E. North Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park**Apr 21 1928*

20 UNDERTAKER

ADDRESS

*Wm. Cook**503 E. North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33065

## CERTIFICATE OF DEATH.

E 33065

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 102 Keswick Rd 27-49

## 2-FULL NAME James E Dixon

(a) RESIDENCE NO. 102 Keswick Rd

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Ora E Dixon

6 DATE OF BIRTH (month, day, and year)

Jan 14 - 1847

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

81

3

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Thomas Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Martha Rine

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Miss Dixon 102 Keswick Rd

15

FILED

APR 20 1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1928

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1927, to April 18, 1928, that I last saw him alive on April 18, 1928, and that death occurred, on the date stated above, at 12-15a. m.

The CAUSE OF DEATH\* as follows:

Terminal Broncho Pneumonia  
Senile Dementia.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Senile Arterio Sclerosis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

No

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physiological

(Signed)

M. H. Johnson, M. D.

4/19/28

(Address) 422 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Parkwood Cemetery

Apr 21 1928

20 UNDERTAKER

A. S. Marshall 3539 Hill Road



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33066

## CERTIFICATE OF DEATH.

31 E 33066

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5037, Central Ave. 58 WARD)

## 2-FULL NAME

Rosetta Green

## (a) RESIDENCE NO.

5037, Central Ave

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

C.

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of or WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 1908

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Va.

## 10 NAME OF FATHER

Bert Green

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Mama Marshall

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

## 14

Informant (Address)

Mama Marshall 5037 Central Ave

## 15

Filed

19

H. M. Jones, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

4/18 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 15, 1928, to April 18, 1928.

that I last saw her alive on April 17, 1928.

and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

## CONTRIBUTORY (Secondary)

Tubercular Bacilli

(duration) yrs. 2 mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

H. M. Jones, M. D.

(Address)

703 W. Lafayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Mount Calvary

Apr 20, 1928

## 20 UNDERTAKER

M. R. G. Elliot

ADDRESS

1725 Ashland Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33067

CERTIFICATE OF DEATH.

90 E 33067

1-PLACE OF DEATH

City of BALTIMORE: (No. 1606 McElderry St St., 7-9 Ward)

2-FULL NAME Richard Woods

(a) RESIDENCE NO. 1606 McElderry St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race C 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beatrice Woods

6 DATE OF BIRTH (month, day, and year) March 10-1887

7 AGE 41 Years Months 0 Days 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(n) Trade, profession or particular kind of work Expressman (b) General nature of industry, business, or establishment in which employed (or employer) Self (c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

10 NAME OF FATHER Walter Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Beatrice Woods 1606 McElderry St.

15 Filed APR 20 1928 C. HAYSON JONES, JR. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17-1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pulmonary Oedema-Chr Myocarditis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Jones M. D. (Coroner)

(Address)

4/18/28 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

White Stone Va Apr 19 1928

20 UNDERTAKER ADDRESS Mrs. R. G. Elliott 125

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 13-59 Ward)2-FULL NAME Solomon Weinstein(a) RESIDENCE NO. 2203 E. Madison Ave St. 13-59 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 20/28

7 AGE Years 25 Months 10 Days 29 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....Clerk

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

Balto., Md.10 NAME OF FATHER Louis Wainstein11 BIRTHPLACE OF FATHER (city or town).....Russia  
(State or country)12 MAIDEN NAME OF MOTHER Sarah Wicker13 BIRTHPLACE OF MOTHER (city or town).....Russia  
(State or country)14 Informant Michael Weinstein (Bro)  
(Address) 2203 Madison AveAPR 20 1928 HELEN JONES, M. D.  
Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928  
Apr 19/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or Inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-inquiry.....and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

General Sepsis-Abscesses of liver  
spleen & kidneys. (Pt of infection n  
Undetermined. Autopsy at Sinai)

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Chr. Cardiac Valv. Disease  
(Secondary)Arteriosclerosis.....yrs. ....mos. ....ds.

(Signed)..... M. D.

4/2/28 (address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Hebrew Cemetery 4/20/28

20 UNDERTAKER ADDRESS

Jack Lewis 1838 E. Balt St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33069  
1. PLACE OF DEATH

BALTIMORE CITY HOSPITAL

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST. 5-8 WARD)

2. FULL NAME *Jacobs Harris*(a) RESIDENCE NO. *119 W. Exeter*  
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *?*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *?*6 DATE OF BIRTH (month, day, and year) *?*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *70*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Presser*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Alfred Harris*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Annie*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant (Address) *Records*15 Filed *C. HARRISON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/13/1928*17 I HEREBY CERTIFY, That I attended deceased from *Mar. 15, 1928, to Apr. 18, 1928*that I last saw him live on *Apr. 18, 1928* and that death occurred, on the date stated above, at *11:25 P. M.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*(duration) yrs. mos. ds. *5*CONTRIBUTORY *Intermittent* (Secondary) *?* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *General + Lab.*(Signed) *C. Harrison Jones*, M. D. 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Rehman Heron Rm*DATE OF BURIAL *4/20/28*UNDERTAKER *Jack Lewis 1439*ADDRESS *1439*

TION is very important. See instructions on back of certificates.



E 33070

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 12th WARD)

## 2. FULL NAME

Miss Janella Weiser

## (a) RESIDENCE NO.

458 Lincoln St. ST. York WARD 1

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Sept 18, 1896

## 7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs or ... min.

3172

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Pa.

## 10 NAME OF FATHER

Harry Weiser

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

## 12 MAIDEN NAME OF MOTHER

Ella Schaffer

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

## 14

Informant (Address)

Parent deceased

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 20, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

April 11, 1928, to April 20, 1928,that I last saw him alive on April 20, 1928and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH was as follows:

Acute cardiac Failure following Pericardial Thymectomy (Pt. Had a Thyroid Storm)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Tolic Chronic Myocarditis

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of April 18Was there an autopsy? NoWhat test confirmed diagnosis? Cy. Examination(Signed) Frank R. Morris, M. D., 19 (Address) Union Memorial Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

York Penna

## DATE OF BURIAL

4/23, 1928

## UNDERTAKER

William Cook

## ADDRESS

502 E. 11th

TION is very important. See instructions on back of certificates.

PR 20 1928

HAMILTON JONES, M. D.

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Linden Ave ST. 11-24 WARD)2-FULL NAME Charles Wilson Thompson(a) RESIDENCE NO. 919 Linden Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE col 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of May E. Thompson6 DATE OF BIRTH (month, day, and year) Aug-5 19097 AGE 39 Years 8 Months 14 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roadster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country) Baltimore, Md.10 NAME OF FATHER Daniel Thompson11 BIRTHPLACE OF FATHER (city or town; State or country) Baltimore, Md.12 MAIDEN NAME OF MOTHER Fannie Matthews13 BIRTHPLACE OF MOTHER (city or town; State or country) Md.14 Informant May E. Thompson  
(Address) 919 Linden Ave15 Filed 1928 REGISTRAR W. H. JONES, JR.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 192817 I HEREBY CERTIFY, That I attended deceased from Mar 22, 1928 to April 19, 1928, that I last saw him alive on April 16, 1928 and that death occurred, on the date stated above, at 10:25 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary T. B.(duration) 7 yrs. 4 mos. ds.CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Thompson, M. D.19 (Address) 817 Hamilton Terrace

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

National Cem4/21/28

20 UNDERTAKER

ADDRESS

Wm. E. Evers916  
B & ave

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33072

## CERTIFICATE OF DEATH.

45 E 33072  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balti City Hospital 17-76 ST. 17-76 WARD)2-FULL NAME Edward Ingram(a) RESIDENCE NO. 719 W Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of May Ingram6 DATE OF BIRTH (month, day, and year) 18837 AGE Years Months Days If LESS than 1 day, hrs. or min. 45

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)10 NAME OF FATHER Edward Ingram11 BIRTHPLACE OF FATHER (city or town) Va (State or country)12 MAIDEN NAME OF MOTHER Patty Hill13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)14 Informant Balti City 18004 (Address)15 Filed C. HAZARD JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19-1928

17

I HEREBY CERTIFY, That I attended deceased from 4-9-1928 to 4-19-1928.that I last saw him alive on 4-19-1928.and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Sclerosis  
Chronic Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Home if not at place of death?Did an operation precede death? NO Date ofWas there an autopsy? NOWhat test confirmed diagnosis? Proctoscopy(Signed) Blumfeld M.D., 19 (Address) Balti City Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Ambrose Church4/21/1928

1. UNDERTAKER

ADDRESS

Samuel E. CarterBa. Md.

TION is very important See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33073

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 33073

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 13-20 Ward)2-FULL NAME R. Belle Moler(a) RESIDENCE NO. 800 W. North Ave., St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Lee Moler

6 DATE OF BIRTH (month, day, and year)  
July 6, 1868.

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
59 9 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.  
(State or country)

10 NAME OF FATHER Robert Boteler

11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Marshall

13 BIRTHPLACE OF MOTHER (city or town) W. Va.  
(State or country)

14 Informant Mr. Lee Moler  
(Address) 800 W. North Ave.

15 FILE 1928 19 HARRISON JONES Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said her (Inquest, au-

inquiry and that said deceased came to her death  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured Hip.

(duration) yrs. mos. ds.

CONTRIBUTORY Shock.  
(Secondary)

(duration) yrs. mos. ds.  
(Signed) Argue J. Allen M. D.  
(Coroner)

4/20 1928 (Address) 2739 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Shepherdstown W. Va. Apr 21 1928

20 UNDERTAKER ADDRESS

Chas. S. Black 742 W. North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33074

CERTIFICATE OF DEATH.

90 E 33074

1-PLACE OF DEATH

City of BALTIMORE: (No. 1114 Bayard St. 11-24 Ward)

2-FULL NAME

James Mc Laughlin

(a) RESIDENCE NO. 1114 Bayard St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 4 mos. 19 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of \_\_\_\_\_ (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 1 - 1873

7 AGE Years 55 Months 4 Days 19 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Thos Mc Laughlin

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mary Gortland

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Alice Mc Laughlin (Address) 129 W La Fayette St

15 Filed 1928 Registrar RPA

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an \_\_\_\_\_ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said \_\_\_\_\_ (Inquest, autopsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis

(duration) \_\_\_\_\_ yrs. 8 mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. B. Lusk M. D.

(Address) Coroner

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence: \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Cathedral Cemetery 4/23/28

20 UNDERTAKER ADDRESS

Chas. P. Macdonald 1111 Royal Ave

Exact statement of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

33075

HEALTH DEPARTMENT—CITY OF BALTIMORE

33075

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3138 Poppleton WARD 21-29)

2-FULL NAME William Maper

(a) RESIDENCE No. 313 S Poppleton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Apr. 19, 1928

7 AGE

Years

Months

Days

If LESS than 1 day 15 hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Breton, Ind

10 NAME OF FATHER

Anthony Maper

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Lith.

12 MAIDEN NAME OF MOTHER

Era Balske

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Lith.

14

Informant (Address)

Anthony Maper  
313 S Poppleton St

15

File

19

R 20 1928

RRH

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 19, 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 19, 1928 to Apr. 19, 1928, that I last saw him alive on Apr. 19, 1928, and that death occurred, on the date stated above, at 7 15 m. The CAUSE OF DEATH\* was as follows:

Acute Broncho-Pneumonia

(duration) 14 hrs. 14 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) 14 hrs. 14 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam etc

(Signed) Phasbman, M. D.

(Address) 888 W Land St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer

April 20, 1928

20 UNDERTAKER

ADDRESS

John Geblianuskas 423 S Poppleton

E 33076

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001 ✓  
E 33076  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 32176, Fair and 1 St., 1 Ward)

2-FULL NAME Raymond Vitale  
(a) RESIDENCE NO. 32176 Fair and St. 1 WardLength of residence in city or town where death occurred 20 yrs. mos. ds.(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18697 AGE Years 59 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER Joseph Vitale11 BIRTHPLACE OF FATHER (city or town) Italy  
(State or country)12 MAIDEN NAME OF MOTHER Ann13 BIRTHPLACE OF MOTHER (city or town) Italy  
(State or country)

14

Informant  
(Address)John J. Allen  
413 S. Eden St.

20 1928

C. L. JONES, JR., M. D.

Per R. R. H. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:  
Trouble Pneumonia

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds.  
Apr 20 1928 (Signed) G. C. Blades M. D.  
(Address) 143 101 Bay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial April 21 192820 UNDERTAKER John A. Moran ADDRESS 3000 Balto St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33077

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 S. Hollington St. WARD 1-3)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

G. HAMPTON JONES, H. B. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1928, to April 18, 1928, that I last saw him alive on April 18, 1928,

and that death occurred, on the date stated above, at 12:15 A. M. The CAUSE OF DEATH\* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? physical signs (Signed) Leo. Hollington, M. D.

(Address) 1937rough St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

011928



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 33078

## CERTIFICATE OF DEATH.

E 33078

1-PLACE OF DEATH 1825 Myrtle Ave --

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William H. Brown

(a) RESIDENCE NO.

1825 Myrtle Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 8 mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Child

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

✓

6 DATE OF BIRTH (month, day, and year)

Jan - 1926

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

3

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

✓

(c) Name of employer

✓

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Fielden Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Prudence Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Fielden Brown

15

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-1928

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1928, to April 20, 1928, that I last saw him alive on April 19, 1928, and that death occurred, on the date stated above, at 6:30 A. M. The CAUSE OF DEATH\* was as follows:

Cerebral Meningitis (Catarrhal)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Pneumonia (Catarrhal)

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? m Date of

Was there an autopsy? m

What test confirmed diagnosis? ✓

(Signed)

Jas. O. Jones

M. D.

, 19

(Address)

1063 Myrtle Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Broad Neck Cemt.

DATE OF BURIAL

4-23-1928

20 UNDERTAKER

E. H. B. Parker

ADDRESS

27 Calvert

Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

20 1928

E 33079

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33079

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Memorial Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *27-53* ST. *27-53* WARD)2-FULL NAME *Mr. Oliver P. McComas*(a) RESIDENCE NO. *209 E. Oakdale Rd*  
(Usual place of abode)ST. *Baltimore* WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 Single, Married, Widowed,  
or Divorced, (write the word)*Married*5a If married, widowed, or divorced  
HUSBAND of *Mrs. O. P. McComas*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Nov. 7, 1872*

7 AGE

*35* Years*5* Months

Days

If LESS than  
1 day, hrs.  
or min.*56**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work *Real business*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Maryland*10 NAME OF FATHER *H. C. McComas*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Ind.*12 MAIDEN NAME OF MOTHER *Mary Barker*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Ind.*

14

Informant  
(Address)*O. P. McComas Jr.  
New York City*

15

1928

*C. HARRISON JONES, R. D.*

Per

*R. R. H.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 19 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*March 17*, 1928, to *April 19*, 1928.that I last saw him alive on *April*, 1928.and that death occurred, on the date stated above, at *5* A. M.

The CAUSE OF DEATH\* was as follows:

*Carcinoma Lung - Left*(duration) *?* yrs. *✓* mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *Yes*Date of *Mar. 12, 1928*  
*Mar 21, 1928*

Was there an autopsy?

What test confirmed diagnosis? *Section*

(Signed)

*R. J. Belford*

M. D.

4-19, 1928 (Address)

*Union Memorial Hosp*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Gruntt Housebury**Apr - 21 / 1928*

20 UNDERTAKER

ADDRESS

*Stewart Howells**Baltimore*

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33080

## CERTIFICATE OF DEATH.

199 E 33080  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2016 Mace St. 12-51 Ward)

## 2-FULL NAME

Martha Parran

## (a) RESIDENCE NO.

1800 Maryland Ave. St. 12-51 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr. 1898

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.39

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

Public

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Va.

## 10 NAME OF FATHER

Cornelius Parran

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Betty Parran

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va.

## 14

Informant (Address)

Barbara Suzanne Friend  
131 W. 20 St.

## 15 Filed

G. H. 11-11-1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured Skull  
Struck on head with  
apex of crowbar  
(Homicide)  
(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) J. H. House M. D.  
(Coroner)4/18, 1928 (Address) 3632 Roland St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. ....mos. ....ds. In the State .....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Int. Cemetery  
John M. JohnsonApr. 19, 28

## 20 UNDERTAKER

ADDRESS 1234Elting St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1928

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26 200 Bks.  
E 33081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

E 33081

1-PLACE OF DEATH

City of BALTIMORE: (No. 309 E. 31<sup>st</sup>.)

2-FULL NAME

(a) RESIDENCE NO. 309 E. 31<sup>st</sup>.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

St. Ward

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Elizabeth Morgan Roberts

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1928

17

I HEREBY CERTIFY, That I attended deceased from

4-12, 1928, to 4-18, 1928.

that I last saw him alive on 4-18, 1928.

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH\* was as follows:

LOBAR PNEUMONIA

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John S. Jones, M. D.

19 (Address) 1129 So. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Rock Spring Cem, Forest Hill, Md. April 1928

20 UNDERTAKER

ADDRESS

John C. Mitchell & Sons 1900 Eutaw Place



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33082

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 N. Durham ST., 7-13 WARD)2-FULL NAME Annie Whitfield(a) RESIDENCE NO. 909 N. Durham ST., 7-13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 14

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleColSingle5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of6 DATE OF BIRTH (month, day, and year) 4-6-1928

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

14 days14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
md.

10 NAME OF FATHER

James Whitfield

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

n.c.

12 MAIDEN NAME OF MOTHER

Delorna Hagan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md.

14

Informant

(Address)

Delorna Whitfield  
909 N. Durham St.

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 20 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 16 1928 to April 20 1928that I last saw her alive on April 20 1928and that death occurred, on the date stated above, at 8 'A m.

The CAUSE OF DEATH\* was as follows:

Hemorrhagic Disease of  
new born

(duration)

yrs.

mos. 5

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos. 14

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Calvin B. LeCompte M. D.

, 19

(Address) 814 N. Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Calvary Cemetery April 24 1928  
Robert Wilson 1515 N. E. 4th St.

TION is very important. See instructions on back of certificates.

E 33083

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33083

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *4349 Reisterstown Road* ST. *58* WARD)2. FULL NAME *PROSPERA VIZZINI*(a) RESIDENCE No. *4349 REISTERSTOWN ROAD* ST. *58* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *30* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Frank Vizzini*

6 DATE OF BIRTH (month, day, and year)

*Dec 22 1892*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*55**3**27*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Italy*

10 NAME OF FATHER

*Paquall Vizzini*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Italy*

12 MAIDEN NAME OF MOTHER

*Antonietta Landeck*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Italy*

14

Informant (Address)

*John Ferrara 4349 Reisterstown*

15

Filed

*C. HAMPTON JONES, Registrar*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-19 1928*

17

I HEREBY CERTIFY, That I attended deceased from *1-19-1928* to *4-19-1928* that I last saw her alive on *4-18-1928*and that death occurred, on the date stated above, at *2 a - m.*

The CAUSE OF DEATH\* was as follows:

*acute multiple arthritis. acute endocarditis.*(duration) yrs. *3* mos. *2* da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *3* da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical*

(Signed)

*S. Demarco* M. D.4-20-1928 (Address) *1608 Linden ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral April 20 1928*

20 UNDERTAKER

ADDRESS

*Frank V. Pipitone 2818 E. 13th*

TUTION is very important. See instructions on back of certificates. Exact statement of O.C.P.A.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33084

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 Laurens St., 16-23 Ward)2-FULL NAME Frank M. Guethlein(a) RESIDENCE No. Larchmont Baltimore Md. Ward \_\_\_\_\_Length of residence in city or town where death occurred 2 yrs. 8 mos. 18 ds. If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced, give name of HUSBAND of (or) WIFE of Louise Guethlein6 DATE OF BIRTH (month, day, and year) Aug 1-18657 AGE Years 62 Months 8 Days 18 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)10 NAME OF FATHER Geo. Guethlein11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Margaret Hoover13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Louise Guethlein (Address) 1209 Laurens15 Date of Death 1928 Registrar PRR

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows: (Accident)  
Asphyxia  
Sudden  
(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) F. B. Lusk M. D. (Address) Coroner.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery Date of Burial 192820 UNDERTAKER Narry W. Chen ADDRESS 1944 W. North

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.  
E 33085  
Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33085

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 N. Carey ST. 19-76 WARD)

2-FULL NAME Emil Schmidtborn

(a) RESIDENCE NO. 524 N. Carey ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emile Marie Schmidtborn

6 DATE OF BIRTH (month, day, and year) Nov 12 1856

7 AGE 71 Years 5 Months 7 Days If LESS than 1 day, hrs. or min. 72 — —

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Emil Schmidtborn

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Miss Anna O. Ehrig (Address) 644 N. Federal St.

15 Filed 1928 Registrar APR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1928

17 I HEREBY CERTIFY, That I attended deceased from April 13 1928 to April 19 1928, that I last saw him alive on April 19 1928, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY Chronic Infectious Nephritis (Secondary) Arteriosclerosis Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination Sydney Charles Gatz M. D. (Signed)

Apr 19 1928 (Address) 114 N. Laurens St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Green Mount Cem.

DATE OF BURIAL Apr 21 1928

20 UNDERTAKER John O. Mitchell

ADDRESS 1908 E. Canton



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33086

## CERTIFICATE OF DEATH.

E 33086

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 902 N. Milton ST., 6-10 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 902 N. Milton ST.,

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Holtzhaus6 DATE OF BIRTH (month, day, and year) Jan 16, 18547 AGE Years 74 Months 3 Days 4 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md10 NAME OF FATHER George Friedrich11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Eva S. Ernst13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Jacob Holtzhaus (Address) 2548 Eagan Place15 Filed 1928, 19 Apr 23 Registrar RRH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 192817 I HEREBY CERTIFY That I attended deceased from April 1 to April 20, 1928, to April 20, 1928, that I last saw him alive on April 19, 1928, and that death occurred, on the date stated above, at 4:30 m. The CAUSE OF DEATH\* was as follows:Mitral Regurgitation  
Spiritis, Diabetes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Findings(Signed) J. H. H. H. H.(Address) 800 N. North Ave

\*State the Disease Causing Death, or in Deaths from External Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy RedeemerDATE OF BURIAL Apr 23 192820 UNDERTAKER W. H. CookADDRESS 502 E North Ave

TION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks. *Ernest L. Pearson*  
E 33087 HEALTH DEPARTMENT - CITY OF BALTIMORE 33087  
CERTIFICATE OF DEATH. 43  
1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 4207 Valley View Ave., ST. 26th WARD)  
2-FULL NAME Ernest L. Pearson  
(a) RESIDENCE No. 4207 Valley View Ave.,  
(Usual place of abode) All his life.  
Length of residence in city or town where death occurred yrs. mos.  
3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed,  
Male White or Divorced, (write the word) Married  
5a If married, widowed, or divorced  
HUSBAND of Catherine Pearson  
(or) WIFE of  
6 DATE OF BIRTH (month, day, and year) Feb. 16, 1868  
7 AGE Years Months Days If LESS than  
60 2 2 1 day, hrs. or min.  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work Mail-man  
(b) General nature of industry, business, or establishment in which employed (or employer) Employee of Post Office  
(c) Name of employer  
9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)  
10 NAME OF FATHER Andrew Pearson  
11 BIRTHPLACE OF FATHER (city or town) Va.  
(State or country)  
12 MAIDEN NAME OF MOTHER Hester Soper  
13 BIRTHPLACE OF MOTHER (city or town) Va.  
(State or country)  
14 Informant Catherine Pearson  
(Address) 4207 Valley View Ave. Raspeburg.  
15 File J. H. HARRISON, JR., M. D. Registrar  
TATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks. *Ernest L. Pearson*  
E 33087 HEALTH DEPARTMENT - CITY OF BALTIMORE 33087  
CERTIFICATE OF DEATH. 43  
1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 4207 Valley View Ave., ST. 26th WARD)  
2-FULL NAME Ernest L. Pearson  
(a) RESIDENCE No. 4207 Valley View Ave.,  
(Usual place of abode) All his life.  
Length of residence in city or town where death occurred yrs. mos.  
3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed,  
Male White or Divorced, (write the word) Married  
5a If married, widowed, or divorced  
HUSBAND of Catherine Pearson  
(or) WIFE of  
6 DATE OF BIRTH (month, day, and year) Feb. 16, 1868  
7 AGE Years Months Days If LESS than  
60 2 2 1 day, hrs. or min.  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work Mail-man  
(b) General nature of industry, business, or establishment in which employed (or employer) Employee of Post Office  
(c) Name of employer  
9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)  
10 NAME OF FATHER Andrew Pearson  
11 BIRTHPLACE OF FATHER (city or town) Va.  
(State or country)  
12 MAIDEN NAME OF MOTHER Hester Soper  
13 BIRTHPLACE OF MOTHER (city or town) Va.  
(State or country)  
14 Informant Catherine Pearson  
(Address) 4207 Valley View Ave. Raspeburg.  
15 File J. H. HARRISON, JR., M. D. Registrar  
TATION is very important. See instructions on back of certificates.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
ST. 26th WARD  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.  
MEDICAL CERTIFICATE OF DEATH  
16 DATE OF DEATH (month, day, and year) April 18, 19 28  
17 I HEREBY CERTIFY, That I attended deceased from April 11, 19 28 to April 18, 19 28, that I last saw him alive on April 18, 19 28, and that death occurred, on the date stated above, at 7:30 A. m.  
The CAUSE OF DEATH\* was as follows:  
Carcinoma of the floor of the mouth.  
(duration) 1 yrs. 2 mos. ds.  
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.  
18 Where was disease contracted if not at place of death?  
Did an operation precede death? No Date of  
Was there an autopsy? No  
What test confirmed diagnosis? None  
(Signed) A. L. Wilkinson, M. D.  
4/18, 19 28 (Address) 5713 Belair Rd., Raspeburg, Md.  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)  
19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL  
Baltimore Cemetery April 21, 19 28  
20 UNDERTAKER ADDRESS  
William Cook 502 E. North Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33088

## CERTIFICATE OF DEATH

90 E 33088

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 924 S. Decker St. Ward)2-FULL NAME William B. Petchum(a) RESIDENCE NO. 1019 S. Stuyvesant St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 10 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (Write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Day

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filed

G. H. JONES, JR., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1928, to April 20, 1928, that I last saw him alive on April 19, 1928, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart DiseaseCONTRIBUTORY Pulmonary Oedema (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs(Signed) I. B. Bronushas M. D.(Address) 3037 O'Donnell St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33089

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *308 N. Poppleton* ST., *18-76* WARD)2-FULL NAME *John R. Buechs*(a) RESIDENCE NO. *308 N. Poppleton*  
(Usual place of abode)Length of residence in city or town where death occurred *40* yrs. mos. ds.

ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed,  
or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of *Grace E*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 14, 1862*

7 AGE

Years *65*Months *9*Days *5*If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work *Cabinet Maker*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)(c) Name of employer *Self*9 BIRTHPLACE (city or town)  
(State or country) *Germany*10 NAME OF FATHER *Henry Buechs*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Wickman*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address) *Grace E Buechs*  
*308 N. Poppleton St*Filed *20-1926*, 19Registrar *R.R.B.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 19 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*Apr. 9<sup>th</sup>*, 1928, to *April 19, 1928*,  
that I last saw him alive on *Apr 19<sup>th</sup>*, 1928,  
and that death occurred, on the date stated above, at *6 A.* m.  
The CAUSE OF DEATH\* was as follows:*Acute Bronchitis*(duration) yrs. mos. ds. *10*CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Robt. J. Murray*, M. D.*4-20, 1928* (Address) *570 N. Fremont Ave*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *London Park*DATE OF BURIAL *Apr 21 1928*20 UNDERTAKER *Wm. Cook*ADDRESS *570 N. Fremont Ave*

TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33090

E 33090

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3522 Esther Place 26-37 WARD)2—FULL NAME Daniel Jagusch(a) RESIDENCE NO. 3522 Esther Place

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.How long in U. S., if foreign birth? 32 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married6 If married, widowed, or divorced HUSBAND of Caroline Jagusch (or) WIFE of6 DATE OF BIRTH (month, day, and year) Oct 8-18577 AGE 70 Years 6 Months 12 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER Adam Jagusch11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Amelia Jagusch (Address) 3522 Esther Place15 Filed APR 20 1928 19 HAMPSON JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 '28

17

I HEREBY CERTIFY, That I attended deceased from about Sept, 1927, to April 19, 1928.that I last saw him alive on April 18, 1928and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Parenchymatous nephritis(duration) 3 yrs. mos. ds.CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? albuminuria(Signed) W. H. Jones, M. D.4/20/1928 (Address) 1014 S. Eldred Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
BURYAL St. MatthewsDATE OF BURIAL Apr 22 192820 UNDERTAKER Miss C. MillerADDRESS 2334 Jeffers

E 33091

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33091

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1004 Aisquith*ST. *10-14* WARDREGISTERED NO. *151*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Thomas B Canoles*(a) RESIDENCE. No. *1004 Aisquith*  
(Usual place of abode)

ST. WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 Single, Married, Widowed,  
or Divorced (write the word)*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Johannah Canoles*

6 DATE OF BIRTH (month, day, and year)

*June 27, 1853*

7 AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.*74**9**21*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Truck Driving*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto.  
Md.*

10 NAME OF FATHER

*William Canoles*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Balto.  
Md.*

12 MAIDEN NAME OF MOTHER

*Elizabeth Schmitt*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balto.  
Md.*

14

Informant  
(Address)*Johannah Canoles  
1004 Aisquith St.*

15

Filed

R 28 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 19 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*home*

1921 to

*April 19 1928*that I last saw him alive on *April 19 1928*and that death occurred, on the date stated above, at *930 P m.*

The CAUSE OF DEATH\* was as follows:

*General Anasarca**Cardiac Decomposition**Sanguine both Large Bow*(duration) *7 yrs?* mos. ds.CONTRIBUTORY *Cardiac Decomposition*  
(Secondary)(duration) *7 yrs?* mos. ds.18 Where was disease contracted  
If not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*

(Signed)

*C. O. Carman*

M. D.

(Address)

*1207 S. Caroline St.*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cem**April 23 1928*

20 UNDERTAKER

ADDRESS

*Mrs. L. Miller & Son**2234 Jefferson St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

20  
J 33092

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 16-76  
CITY OF BALTIMORE: (No. 16-76 ST. WARD)

2-FULL NAME Ella Holland

(a) RESIDENCE NO. 609 E. Carey ST. Federick Md  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. ds. mos. ds.

REGISTERED NO. 33092  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)  
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE black 5 Single, Married, Widowed, or Divorced, (write the word) married  
If married, widowed, or divorced  
HUSBAND of Frank Holland  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE 46 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Md  
(State or country)10 NAME OF FATHER Henry11 BIRTHPLACE OF FATHER (city or town) Md  
(State or country)12 MAIDEN NAME OF MOTHER Mary Blackstone13 BIRTHPLACE OF MOTHER (city or town) Md  
(State or country)14 Informant Records  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1928, to April 19, 1928, that I last saw her alive on April 19, 1928, and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH\* was as follows:

Exophthalmic goiter

CONTRIBUTORY (Secondary) Hypothyroid crisis  
(duration) yrs. 8 mos. ds.  
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? YesWhat test confirmed diagnosis? Basal Metabolism +80(Signed) Christy P. Johnston M. D.4/19/28 Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Federick MdUNDERTAKER Samuel DeaneleyDATE OF BURIAL 4-21-28ADDRESS 578

21 1928

G. HAMPTON JONES JR.

E 33093

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *9-46* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *704 E. 23rd*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.ST. *9-46* WARD

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *white*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 19, 1918*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*10 NAME OF FATHER *Joseph E Sears*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md*12 MAIDEN NAME OF MOTHER *Margaret Bell*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md*

14

Informant (Address) *Joseph E Sears 704 E. 23rd St*

15

Filed

G. HANSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/20/1928*

17

I HEREBY CERTIFY, That I attended deceased from *4/16/28*, 19, to *4/20/28*, 19, that I last saw her alive on *4/20/28*, 19, and that death occurred, on the date stated above, at *3:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*severe spinal meningitis*CONTRIBUTORY (Secondary) *cardiac dilatation* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Lawrence Holmes, M. D.*, 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER *Western*ADDRESS *502 E North St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33094

## CERTIFICATE OF DEATH.

E 33094

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *3306 Schuck* St. *76-2* Ward)2-FULL NAME *Geo Preller*(a) RESIDENCE NO. *3306 Schuck* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *23* yrs. *6* mos. *23* ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 26/1907*7 AGE Years *23* Months *6* Days *23* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Bricklayer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.*

(State or country)

10 NAME OF FATHER *Conrad Preller*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Mollie Gossman*13 BIRTHPLACE OF MOTHER (city or town) *Balto. Md.*

(State or country)

14 Informant *Harry M. Preller Father*  
(Address) *3306 Schuck St*15 *1928* *19* *11/11/1928* Registrar *RRB*

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 18 1928*17 I HEREBY CERTIFY that I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said *Inquest*find that said deceased came to *death* (topsy or inquiry)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Epilepsy*CONTRIBUTORY *Caustion* (duration) yrs. mos. ds.*Apr. 18 1928* (duration) yrs. mos. ds.*128* (signed) *Geo C. Bladed* M. D.

(Coroner)

*19* (Address) *143 W. 1st St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Sacred Heart Cemetery* Date of Burial *Apr. 21 1928*20 UNDERTAKER *Lilly & Guiler Inc.* ADDRESS *403 N. Wolfe St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33095

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Square Hospital*CITY OF BALTIMORE: (No. *100 Calhoun*)ST. *70-37* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Anna Dietrich*(a) RESIDENCE No. *522 S 14th St*  
(Usual place of abode)ST. *24* WARDLength of residence in city or town where death occurred *2* yrs. *9* mos. *21* ds.  
(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 28 1925*7 AGE Years *2* Months *9* Days *21* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md*  
(State or country)10 NAME OF FATHER *Leo Dietrich*11 BIRTHPLACE OF FATHER (city or town) *Penn*  
(State or country)12 MAIDEN NAME OF MOTHER *Mary Fauer*13 BIRTHPLACE OF MOTHER (city or town) *Balto. Md*  
(State or country)14 Informant *Leo Dietrich Father*  
(Address) *522 S 14th St*15 *21 1928* *HANSON JONES M. A.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-19 1928*17 I HEREBY CERTIFY, That I attended deceased from *4-17 1928* to *4-19 1928*, that I last saw her alive on *4-19 1928*and that death occurred, on the date stated above, at *4 40 A* m.

The CAUSE OF DEATH\* was as follows:

*Pneumococcus Peritonitis*  
*(primary focus unknown)*(duration) yrs. mos. *5* ds.CONTRIBUTORY *Pneumococcus Septicemia*  
(Secondary)(duration) yrs. mos. *2* ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *Yes* Date of *4-17-28*

Was there an autopsy?

What test confirmed diagnosis? *Operation*(Signed) *Louis H. Hollen*, M. D.19 (Address) *Franklin Square Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cem.**April 20 1928*

20 UNDERTAKER

ADDRESS

*Lilly & Geiler Inc**403 S. W. 1st St*

TION is very important. See instructions on back of certificates.

E 33096

## HEALTH DEPARTMENT—CITY OF BALTIMORE

J 33096

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balt City Hospital*)

WARD)

2-FULL NAME *John Vanloosen*(a) RESIDENCE NO. *Balt City Hospital*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

*Male**White**Unknown*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*76*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Holland*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

*Balt City Hospital*

15

Filed

G. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4-17 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*4-4 1928 to 4-17 1928*that I last saw him live on *4-17 1928*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Generalized Osteoporosis Chronic Myocarditis Benign Prostatic Hypertrophy Chronic Urinary Retention Bilateral Pyonephrosis (duration) Subacute*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

*Laboratory Physical*

(Signed)

*Blaylock M. D.*

19

(Address)

*Balt City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Holy Cross A.A.*

DATE OF BURIAL

*4-21 1928*

20 UNDERTAKER

*John J. Traylor*

ADDRESS

*315 E. 1st St*

E 33097

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *4098 Chaple* ST. *2-4* WARD)2-FULL NAME *Latherine Zakoseelny*(a) RESIDENCE NO. *4098 Chaple*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 19-27*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Wladyslaw Zakoseelny*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*12 NAME OF MOTHER *Prunckowrak*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md*

14

Informant (Address) *Prunckowrak*

15 1928

C. HAMPSON, JONES, R. H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-20-28*

17

I HEREBY CERTIFY, That I attended deceased from

*April 17, 1928, to April 20, 1928.*that I last saw him alive on *April 20, 1928.*and that death occurred, on the date stated above, at *6 PM*

The CAUSE OF DEATH\* was as follows:

*Pneumonia Broncho Pneumonia*  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Andrew K. ...*, M. D.(Address) *7579 Eastern Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVING

20 UNDERTAKER

ADDRESS

*Holy Rosary April 21, 1928*  
*J. W. Gajewski 81930*



E 33098

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33098

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital 45-21* WARD)2-FULL NAME *Baby Girl Holton*(a) RESIDENCE NO. *1518 N. Stricker* ST.,(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Female Black*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

G. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
*4/14*, 19*28*, to *4/19*, 19*28*.that I last saw *alive* on *4/19*, 19*28*,  
and that death occurred, on the date stated above, at *9:45 P.m.*

The CAUSE OF DEATH\* was as follows:

*Bronchio-pneumonia*

(duration)

yrs.

mos.

3 ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Phy exam*

(Signed)

*Wright Reynolds* M. D.

19

(Address)

*University Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

*Edward Bryan*

ADDRESS

*1631 Orleans St*

TION is very important. See instructions on back of certificates.



E 33100

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33100

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals (11B) ST. 31 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gains(a) RESIDENCE No. 802 S. Sharpe st.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos.ST. 31 WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of or WIFE of Daniel Gains6 DATE OF BIRTH (month, day, and year) 19047 AGE Years 24 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina10 NAME OF FATHER George Benerman11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina12 MAIDEN NAME OF MOTHER C. Kelly13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina14 Informant Hospital Records (Address)15 21-1928 G. HARRISON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 192817 I HEREBY CERTIFY, That I attended deceased from March 19, 1928 to April 19, 1928that I last saw her alive on April 19, 1928and that death occurred, on the date stated above, at 6.10 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis.(duration) Unknown yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Clinical & autopsy(Signed) J. E. Meade M. D.4-20-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33101

## CERTIFICATE OF DEATH.

31 E 33101

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 378. Hare

ST. 1-11

WARD

## 2-FULL NAME

William H. C. Sewell

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No. 378. Hare

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced? (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

Catherine Sewell

6 DATE OF BIRTH (month, day, and year)

May 15 1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

11

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Ship-fitter

9 BIRTHPLACE (city or town) (State or country)

Ind.

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

21-1928

G. H. HARTSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 19 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 1st 1928 to April 19 1928

that I last saw him alive on April 19 1928

and that death occurred, on the date stated above, at 1.10 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

D. J. Amman, M. D.

(Address)

2913 E. Baltimore

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Oaklawn Cemetery

April 23, 1928

John A. Moran 3000 E. Baltimore St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33102

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1223 E Preston*)St. *10-14* Ward2-FULL NAME *Anna Stiemke*(a) RESIDENCE NO. *1223 E Preston St*

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred *40* yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? *5* yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Timotheus Stiemke*

6 DATE OF BIRTH (month, day, and year)

*March 12 1857*

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

*71**1**8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

*Germany*

(State or country)

10 NAME OF FATHER

*M. Schoening*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Margaret Bowman*

13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

*Germany*

14

Informant (Address)

*Rudolph G. Stiemke  
1223 E Preston St*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 20 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 10 1928* to *Apr 20 1928*that I last saw her alive on *Apr 20 1928*and that death occurred, on the date stated above, at *11:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*  
(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

CONTRIBUTORY

(Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Physical*(Signed) *J. H. Jones* M. D.(Address) *12281 Pennsylvania*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Immanuel Cem**4/23 1928*

20 UNDERTAKER

ADDRESS

*Louis Heemann**37 S B way*

Very important. See instructions on back of certificates.

21 1928

G. H. JONES, Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33103

## CERTIFICATE OF DEATH.

48 E 33103

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 McElderry St. ST., 14-20 WARD)2-FULL NAME Alro L Bowen(a) RESIDENCE No. 1921 McElderry St. ST., 14-20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female4 COLOR OR RACE W.C.5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas H Bowen6 DATE OF BIRTH Dec 19 — 1861

7 AGE

Years 66Months 4

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina10 NAME OF FATHER John Overly11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa12 MAIDEN NAME OF MOTHER Lucia Britt13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14

Informant (Address) John Overly  
1921 McElderry St.

21 1928

C. HANFORD JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1928

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to April 19, 1928 that I last saw her alive on April 18, 1928 and that death occurred, on the date stated above, at 11-5 P m.

The CAUSE OF DEATH\* was as follows:

Epithelioma  
Cancer of skin  
Lower part of trunk & body  
buttock (duration) yrs. 9 mos. ds.CONTRIBUTORY (Secondary) Toxemia (duration) yrs. 9 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Section of area  
examined by microscope  
(Signed) Dr. M. Kieffer, M. D.Date April 20, 1928 (Address) 2324 North Blue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOTAL Brooklawn CemDATE OF BURIAL Apr 23, 192820 UNDERTAKER John UlrichADDRESS 2008 Atkins

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33104

## CERTIFICATE OF DEATH.

46 E 33104  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 538 Greenwillan Ward 17-24)2-FULL NAME Mitchie Ella Jones(a) RESIDENCE NO. 538 Greenwillan Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 26 mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race W.C.5 Single, Married, Widowed,  
or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of William Jones6 DATE OF BIRTH (month, day, and year) Mar 16-1888

7 AGE

Years 40Months 1Days 4IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Lundness(b) General nature of industry,  
business, or establishment in  
which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) 2a

(State or country)

10 NAME OF FATHER Emmanuel Green11 BIRTHPLACE OF FATHER (city or town) 2a

(State or country)

12 MAIDEN NAME OF MOTHER Louisa Robinson13 BIRTHPLACE OF MOTHER (city or town) 2a

(State or country)

14

Informant  
(Address) Winnie Matthews  
538 Greenwillan

15

F. H. HARRISON

Signature

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an.....  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-

topsy or inquiry.) and that said deceased came to..... death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Uterus.(duration) ..... yrs. 3 mos. .... ds.CONTRIBUTORY  
(Secondary)

(duration) ..... yrs. .... mos. .... ds.

(Signed) T. B. Frank

(Coroner) M. D.

Apr 21-1928  
(Address) Coroner\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Remedy Whf. - 29 Date of Burial 4/21/192820 UNDERTAKER Samuel CarterADDRESS 916  
Be w

very important. See instructions on back of certificate.

3282  
33105

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

Black

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town; State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town; State or country)

14

Informant  
(Address)

15

1928

G. HARRISON JONES, JR.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Apr. 19 1928, to Apr. 20 1928,  
that I last saw her alive on Apr. 20 1928,  
and that death occurred, on the date stated above, at 8 50 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia  
with lung.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

at home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Allan Blossom, M. D.

19 (Address)

The Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Tabernacle. Md

DATE OF BURIAL

20 UNDERTAKER

W. H. Archer

ADDRESS

Benson Md



E 33106

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33106

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1432 Regt* St. *23-34* Ward)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Pence*(a) Residence No. *1432 Regt*

(Usual place of abode)

St. ....

Ward. ....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *70* yrs. *0* mos. *9* ds.

How long in U. S., if of foreign birth? yrs. ....

mos. ....

ds. ....

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*6a-If married, widowed, or divorced HUSBAND of (or) WIFE *James Pence*6-DATE OF BIRTH (month, day and year) *April 11<sup>th</sup> 1858*7-AGE *70* yrs. *0* mos. *9* ds.

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *House Work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) *Balto Md*10-NAME OF FATHER *Robert Davis*11-BIRTHPLACE OF FATHER (city or town) (State or Country) *Balto Md*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (city or town) (State or Country) *Balto Md*14- (Informant) *James Pence*(Address) *10 W. Cross st*

15-

1928 C. HARRISON JONES

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *April 20/28*I HEREBY CERTIFY, That I attended deceased from *Jan 1* to *28 April 20* 19 *28*that I last saw him alive on *April 19* 19 *28*and that death occurred, on the date stated above, at *9 A* m.

The CAUSE OF DEATH\* was as follows:

*Mitral Regurgitation**Endocarditis*

CONTRIBUTORY (Secondary)

(Duration) yrs. .... mos. ....

18-Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. P. Campbell* M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL *Cedar Hill Cem*DATE OF BURIAL *April 23<sup>rd</sup>* 19 *28*20-UNDERTAKER *O. Schomander*ADDRESS *1039*

E 33107

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33107

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5912 Pimlico Rd ST., 27-55 WARD)

## 2-FULL NAME Edna M. Russell.

(a) RESIDENCE NO. 5912 Pimlico Rd ST., 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 6 mos. 20 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edw. L. Russell

6 DATE OF BIRTH (month, day, and year)

Oct. 1 - 1897

7 AGE

Years

Months

Days

30

6

20

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Oliver H. Reeside

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ellicott City Md.

12 MAIDEN NAME OF MOTHER

Ida Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Red Bank Del. Md.

14

Informant (Address)

E. L. Russell

15

Filed

27 1928

HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 20 th 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 20 (5 AM) 1928 to Apr. 20 5:45 A.M. 1928 that I last saw her alive on April 20, 1928.

and that death occurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? 2125 Chelsea Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin &amp; mic.

(Signed) Sherman R. Warr, M. D.

4/20/28 (Address) 2601 Manhattan Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL Donald Ridge

DATE OF BURIAL

4/23 1928

20 UNDERTAKER

J. F. McCully 130 S. Front

E 33108

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33108

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 E. Preston

ST. 11-19 WARD)

## 2-FULL NAME

Elizabeth Lochte

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

418 E. Preston

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 59 yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Albert J. Lochte

## 6 DATE OF BIRTH (month, day, and year)

March 25, 1857

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

0

24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ireland

## 10 NAME OF FATHER Michael Burns

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER --- Fitzsimmons

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

## 14

Informant (Address)

Mr. Edw. Lochte

418 E. Preston St.

## 15

1928

C. HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 9, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1928, to April 19, 1928.

that I last saw her alive on April 19, 1928.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 19 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Eugene P. Passavant, M. D.

4, 20, 1928 (Address) 514 Drury Lane

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cemetery

## DATE OF BURIAL

4/23 1928

## 20 UNDERTAKER

## ADDRESS

Henry H. Mears 805 N. Calver

E 33109

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

10-01 E 33109

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *9-18* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Joseph Ficker, Jr.*(a) RESIDENCE No. *1536 Airquith*

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 22, 1924*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*3**6**29*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Joseph Ficker, Sr.*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balt. Md.*

12 MAIDEN NAME OF MOTHER

*Catherine Trueman*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balt. Md.*

14

Informant (Address)

*Joseph Ficker, Sr. 1536 Airquith St.*

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 19, 1928*, to *April 20, 1928*, that I last saw him alive on *April 20, 1928*, and that death occurred, on the date stated above, at *2:55 p.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria - Laryngeal, Toxic and Pharyngeal*(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

*Acute myocarditis*(duration) yrs. mos. *?* ds.

18 Where was disease contracted if not at place of death?

*At home*

Did an operation precede death?

*Yes*Date of *4-20-28*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Bacteriological*

(Signed)

*J. K. Levin M. D.*4-20-28 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Redeemer Church**April 21 1928*

20 UNDER-TAKER

ADDRESS

*George - J. Potts 1735 Harford an*





E 33111

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33111

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 25 mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Col

Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

HARRISON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb-16, 1928, to April 20, 1928, that I last saw him alive on April 20, 1928, and that death occurred, on the date stated above, at 12:30 p. m.

The CAUSE OF DEATH\* was as follows:

Rheumatic heart disease

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed)

, 19 (Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

E 33112

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33112

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1230 Suid Hill* ST. *17-24* WARD)REGISTERED NO. *90*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Laurence B. Dickerson*(a) RESIDENCE NO. *1230 Suid Hill* ST. WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*colored*

5 Single, Married, Widowed, or Divorced, (write the word)

*married*

5a If married, widowed, or divorced.

HUSBAND of  
(or) WIFE of*of Viola Dickerson*6 DATE OF BIRTH (month, day, and year) *? 1890*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*38*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Taylor*

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*St Louis Mo.*10 NAME OF FATHER *Henry Dickerson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Frederick*12 MAIDEN NAME OF MOTHER *Mary Spaulding*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Frederick*

14

Informant  
(Address)*Mary Spaulding  
230 Suid Hill*

15

File

19

*HAMMOND JONES*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 19, 1928*

17

I HEREBY CERTIFY, That, attended deceased from

*Nov. 28, 1928, to April 19, 1928,*that I last saw him alive on *April 19, 1928*and that death occurred, on the date stated above, at *5 a.m.*

The CAUSE OF DEATH\* was as follows:

*myocarditis*(duration) yrs. *6* mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Edw. J. Whelan*, M. D.(Address) *1230 Suid Hill*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*NOVA  
Mt. Auburn**4/21/1928*

20 UNDERTAKER

ADDRESS

*Mrs. Geo. H. Holla 1631 Suid Hill  
Baltimore*

4.33113

## HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 4.33113

CITY OF

## CERTIFICATE OF DEATH.

CITY OF

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bald City Hospital 16-37* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Southern Avenue*(a) RESIDENCE NO. *Bald City Hospital* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? *50* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Charles Huber*6 DATE OF BIRTH (month, day, and year) *1855*7 AGE Years Months Days *73* LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *Huber*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Huber*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Charles Huber* (Address) *705 S. Dallas St.*15 *1828* *C. HAMMOND JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 17 1928*17 I HEREBY CERTIFY, That I attended deceased from *3-29-* 19 *28* to *4-17-* 19 *28* that I last saw *her* alive on *4-17-* 19 *28* and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH\* was as follows:

*Coronary Calcium*

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *France*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Autopsy*(Signed) *Blaylock M. D.*, 19 (Address) *Bald City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St. Carmel Cem*DATE OF BURIAL *4/21/28*

20 UNDERTAKER

ADDRESS

*George J. Rath 1735 Hampden*



E.33114

E.33114

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E.33114

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Sinai Hospital

CITY OF BALTIMORE: (No.

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James Tennant

(a) RESIDENCE NO.

702 W Fayette St

(Usual place of abode)

Length of residence in city or town where death occurred

40

yrs.

mos.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 28, 1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

Electrician

(c) Name of employer

James Tennant

9 BIRTHPLACE (city or town) (State or country)

Va

10 NAME OF FATHER

William W Tennant

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

R. Beckerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Mattie Thompson  
702 W Fayette St

15

Filed

19

JAMES TENNANT  
RRR Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-20 1928

I HEREBY CERTIFY, That I attended deceased from

4-16, 1928, to

4-20, 1928

that I last saw him alive on

4-20, 19

and that death occurred, on the date stated above, at

1320 m

The CAUSE OF DEATH\* was as follows:

Chronic nephritis  
Uremia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

J. Schuchel

M.D.

, 19 (Address)

Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Oak Lawn

April 22, 28

20 UNDERTAKER

W. E. Gussom

ADDRESS

841 W 37th St



E 33116

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 E 33116

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3209 Eastern Ave ST. 76-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Echel Estelle Taylor(a) RESIDENCE NO. 3209 Eastern Ave ST.,

WARD

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.  
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced  
HUSBAND of Wm. Edgar Taylor  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 13-18967 AGE Years Months Days If LESS than 1 day, hrs. or min.  
31 11 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) md10 NAME OF FATHER Harry C. Phillips11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore, md.12 MAIDEN NAME OF MOTHER Mary E. Frazer13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Baltimore, md.14 Informant Wm. Edgar Taylor  
(Address) 3209 Eastern Ave

1928

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19-192817 I HEREBY CERTIFY, That I attended deceased from Jan -, 1927, to April 19-, 1928,  
that I last saw her alive on April 19-, 1928and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH\* was as follows:

Chronic - Valvular - Cardiac Dis -CONTRIBUTORY  
(Secondary)(duration) 1 1/2 yrs. — mos. — ds.18 Where was disease contracted  
if not at place of death? ✓Did an operation precede death? noDate of ✓Was there an autopsy? noWhat test confirmed diagnosis? ✓(Signed) Dr. C. Hampton Jones

M. D.

19

(Address) 125 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathlamet CemeteryApril 21, 28

20 UNDERTAKER

ADDRESS

George W. Zinkler1737 E. Eager

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33117

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 716 S - 7th St. 16-37 Ward)2-FULL NAME Frank L. Kienhold(a) RESIDENCE NO. 716 S - 7th St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced (write the word)

Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Elizabeth Kienhold

6 DATE OF BIRTH (month, day, and year)

Nov. 27<sup>th</sup> 1891

7 AGE

36 yrs.

4 Months

Days 23

IF LESS than

1 day.....hrs.

or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Crane Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

Electric Works

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto Ind.

10 NAME OF FATHER

Frank Kienhold

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Adelman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto Ind.

14

Informant (Address)

Miss Madeline Kienhold  
311 S. Second St

15

16

17

18

19

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 20 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bronchitis

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

21/2/28 (Signed) G. C. Blad mos. 1 ds.(Address) 143 N. Bway M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

BK Lawn Cem. Apr. 23<sup>rd</sup> 28

20 UNDERTAKER

Lilly & Feiler Inc. 403 S. Wolfe St.

Very Important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33118

## CERTIFICATE OF DEATH.

12 E 33118

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital Ward 1-1)

## 2-FULL NAME

(a) RESIDENCE NO. 710 S. Linwood St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Dec. 24 1893

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

34

3

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Elevator Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

Police Building

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Balto. Ind.

(State or country)

## 10 NAME OF FATHER

Valentine Jordan

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto. Ind.

## 12 MAIDEN NAME OF MOTHER

Bridget During

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto. Ind.

## 14

Informant  
(Address)Valentine Jordan  
710 S. Linwood av

## 15 Filed

G. HANCOCK JONES, M. D.  
Registral

27 1928

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

## 17

I HEREBY CERTIFY that I took charge of the

remains described above, held no

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquest, autopsy or inquiry, and that said deceased came to

death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Septic Infection  
of Gall BladderCONTRIBUTORY  
(Secondary)

Duration yrs. mos. ds.

(Address)

M. D.

Apr 24 1928  
143 N. 3rd way

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

Oak Lawn Cem Apr. 24 1928  
Lilly & Geiler Inc. 403 Wolfe St.

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

218162  
E 33119

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 7-9 WARD)

2-FULL NAME

Robert L. Hardage

(a) RESIDENCE NO.

Florida Casket Co

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

5

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

5-9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Florida

10 NAME OF FATHER

J. J. Hardage

11 BIRTHPLACE OF FATHER (city or town)

Ga.

(State or country)

12 MAIDEN NAME OF MOTHER

Lucy France

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ga.

14

Informant  
(Address)

JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Apr. 16 1928, to April 21 1928.  
that I last saw him live on April 21 1928.  
and that death occurred, on the date stated above, at 1:35 p.m.

The CAUSE OF DEATH\* was as follows:

Brain tumor

Post-operative pneumonia

(duration) 12 yrs. mos. 3 ds.

CONTRIBUTORY  
(Secondary)

Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of 4/16/28

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. J. Moran M. D.

19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Atlanta, Ga.

4/22/28

20 UNDERTAKER

ADDRESS

J. J. Moran

E. Balt.

R 22 1928

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33120

## CERTIFICATE OF DEATH.

71E 33120  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 76-37 WARD)

2-FULL NAME Louis Zlotovitch

(a) RESIDENCE No. 4501 Eastern Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Bessie Zlotovitch

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs or min  
35 — — —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant. 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland.  
(State or country)

10 NAME OF FATHER Maurice

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Poland.14 Informant Bessie Zlotovitch  
(Address) 4501 Eastern Ave

15 Filed 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 16, 1928, to April 21, 1928.

that I last saw him alive on April 21, 1928,

and that death occurred, on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH\* was as follows:

Septic Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Sinusitis, (Antra & Ethmoidal)  
(Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted  
if not at place of death? Home

Did an operation precede death? Yes Date of 4-17-28

Was there an autopsy? No

What test confirmed diagnosis? Clinical &amp; Laboratory

(Signed) Sherman J. Garrett, M. D.

4-21, 1928 (Address) University Hospital

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Hebrew Rosedale

DATE OF BURIAL

4/22 1928

20 UNDERTAKER

Jack Lewis 1439 E. Baltimore St.

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33121

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 N. Smallwood

ST. 15-68 WARD)

## 2-FULL NAME

Morris Jacob Schwartz

(a) RESIDENCE NO.

1719 N. Smallwood

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr 1 - 1925

7 AGE

Years

2

Months

5

Days

20

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto., Ind.

10 NAME OF FATHER

Abraham Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Fannie Rosen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Abraham Schwartz (Father) 1719 N. Smallwood

15

Filed

R 22 1928

H. J. JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1928

17

I HEREBY CERTIFY, That I attended deceased from 4/28 - 1928, to 4/21 1928, that I last saw him alive on 4/20/28 1928

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 3

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Goldberg M. D. 4/21, 1928 (Address) 2210 E. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Helen Nash Road

DATE OF BURIAL

4/22 1928

UNDERTAKER

Jack Lewis 1434 E. Baltimore



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33122

E 33122

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST., \_\_\_\_\_

WARD \_\_\_\_\_

2-FULL NAME Eza Chamberlain(a) RESIDENCE NO. 1836 Westmore ST., 222 WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female

Black

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year) 2-7-17

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

11

2

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Home

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Pa -

10 NAME OF FATHER

Ernest

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Pa -

12 MAIDEN NAME OF MOTHER

Orlean Higgins

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Pa -

14 Informant  
(Address)

Reynolds

15 Filed 2-2-1928

C. H. JONES, JR., Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 21 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Apr. 14, 1928, to April 21, 1928.  
that I last saw her alive on Apr. 21, 1928.  
and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis with Edema  
of heart  
from(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)Primary pericarditis  
Pneumonia, lobar  
(duration) 4 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

at home

Did an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Urinalysis, pericardial culture(Signed) J. B. Bennett, M. D.Address Johns Hopkins Hospital\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
BURYAL

DATE OF BURIAL

Buried at home4-22-1928

20 UNDERTAKER

ADDRESS

Ernest J. Jones, Jr.  
1135 E. Pratt

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33123

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *3-5* WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

C. H. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/21/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*4/20/28*, 19, to *4/21/28*, 19that I last saw her alive on *4/21/28*, 19and that death occurred, on the date stated above, at *1 P* m

The CAUSE OF DEATH\* was as follows:

*broncho-pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *cardiac dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Lawrence Fabrey, M. D.*, 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*Wendell J. Aliphal**April 23, 1928*  
*3001 Colver St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33124

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Balto Gen. Hosp*)

## 2. FULL NAME

(a) RESIDENCE NO. *207 S. Mount*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

22 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and this death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33126

31 E 33126

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

City Hospital 15-21 Ward

## 2-FULL NAME

Helen Anderson

## (a) RESIDENCE NO.

1406 N. Gilman St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX J. 4 Color or Race C. 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 27 1911

7 AGE 16 Years 17 Months 22 Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Va

## 10 NAME OF FATHER

William Anderson

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Annie Lane

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va

## 14

Informant (Address)

Mary Anderson  
1406 N. Gilman St.

## 15 Filed

1928

MAR 22 1928

HALL (Registrar)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 19 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

T. B.

## CONTRIBUTORY (Secondary)

Signed 19/28

(Address) 14318 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Lanham Cemetery

Apr. 23 1928

## 20 UNDERTAKER

Mrs. R. A. Elliott

ADDRESS 1725 Ashland Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33127

E 33127

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

Mercy Hosp. 20-27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Joe. Putnam 5-18 Bruce

(a) RESIDENCE NO.

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

white

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emeline Putnam

6 DATE OF BIRTH (month, day, and year)

Feb 19, 1883

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

45-

2

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Elmer M. Co. up 27

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Emeline Putnam 518 Bruce St

15 Filed..... 19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928

Apr 20 28

17

I HEREBY CERTIFY, that I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Coronary Sclerosis

Gen heart

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. .... mos. .... ds.

(Signed) W. J. Ray M. D.

(Coroner)

, 1928 Address)

1039 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death..... yrs. .... mos. .... ds. State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death:

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park

Apr 24 1928

20 UNDERTAKER

ADDRESS

J. M. Cook

507 E North Ave

Very Important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33128

## CERTIFICATE OF DEATH.

100-001

E 33128

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1913 Herbert ST. 15-21 WARD)

2-FULL NAME *Flem. L. Malone*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1913 Herbert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. ☒ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 21-1927*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *5.4 29*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md* (State or country)10 NAME OF FATHER *Win Malone*11 BIRTHPLACE OF FATHER (city or town) *Balto* (State or country)12 MAIDEN NAME OF MOTHER *Annie Ashley*13 BIRTHPLACE OF MOTHER (city or town) *Balto Md* (State or country)14 Informant *Mrs Annie Ashley* (Address) *1913 Herbert St.*15 Filed *C. H. JONES, JR.* 19 *APR 23 1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-20 1928*17 I HEREBY CERTIFY, That I attended deceased from *4-18 1928*, to *4-20 1928*that I last saw her alive on *4/20 1928*and that death occurred, on the date stated above, at *4.15 PM*The CAUSE OF DEATH\* was as follows: *Pneumonia*CONTRIBUTORY (Secondary) *Pulmonary Edema* (duration) yrs. mos. *9* ds.18 Where was disease contracted if not at place of death? (duration) yrs. mos. *1* ds.Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Exam* (Signed) *Wm J. Jones, Jr.*, M. D.4/21, 1928 (Address) *1928 Baltimore*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL *Woodlawn* DATE OF BURIAL *Apr 23 1928*UNDERTAKER *Wm Cook* ADDRESS *307 E North Ave*

TION IS VERY IMPORTANT. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33129

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 Clifton Av. ST., 15-61 WARD)2-FULL NAME Lydia Coulter Gibson(a) RESIDENCE NO. 3004 Clifton Av. ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. ? mos. ? ds.

WARD

REGISTERED NO. 57 E 33129  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 61 yrs. 11 mos. 12 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. L. Gibson6 DATE OF BIRTH (month, day, and year) May-8-18667 AGE Years 61 Months 11 Days 12 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) Elderton  
(State or country) Penna.10 NAME OF FATHER David B. Coulter11 BIRTHPLACE OF FATHER (city or town) Elderton  
(State or country) Penna.12 MAIDEN NAME OF MOTHER Rachel Smith13 BIRTHPLACE OF MOTHER (city or town) Elderton  
(State or country) Penna.14 Informant Thos. L. Gibson (husband)  
(Address) 3004 Clifton Av.15 Filed C. H. JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 16, 1928, to Apr 20, 1928, that I last saw her alive on Apr 20, 1928, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Diabetic Coma  
(Diabetes)CONTRIBUTORY (Secondary) Diabetes Mellitus  
(duration) 4 yrs. — mos. — ds.18 Where was disease contracted if not at place of death? not known  
(duration) 4 yrs. — mos. — ds.Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Clinical & Chemical  
(Signed) S. A. Dodds, M. D.  
Re 20 1928 (Address) 904 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Gravel Ridge Cemetery DATE OF BURIAL Apr 23/1928FUNERAL UNDERTAKER Stewart & Munn ADDRESS Balto.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33130

E 33130

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mary Hospital St. 9-4-6)2-FULL NAME Charles Edward Trace(a) RESIDENCE NO. 2000-E-30

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ? mos. ? ds.St. 9-4-6 Ward 9-4-6(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Florence P. Trace

6 DATE OF BIRTH (month, day, and year)

December - 24 - 1861

7 AGE

Years

Months

Days 28

IF LESS than 1 day.....hrs. or.....min.

663

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

SalesmanAutomobilesCleveland Co.

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15 FILE

22 1928

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 21 1928

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry.) and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valv. pressure heart

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. J. P. Ray M. D.(Address) 1639 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State 14 yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2000-E-30-St.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cochranston - Pa. April 1928

20 UNDERTAKER

Stewart Thomas Balto.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33131

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 74)

## 2. FULL NAME

Alphonse Caldwell

## (a) RESIDENCE NO.

(Usual place of abode)

M<sup>c</sup> Lanei -

Length of residence in city or town where death occurred

yrs.

mos.

25<sup>7</sup> ds.

ST.

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Black

## 5 Single, Married, Widowed, or Divorced, (write the word)

—

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Md -

## 10 NAME OF FATHER

Charles Caldwell

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md -

## 12 MAIDEN NAME OF MOTHER

Ethel M. Adams

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md -

## 14

Informant  
(Address)

Records -

## 15

Filed

G. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
March 26, 1928, to April 21, 1928.  
that I last saw him alive on April 21, 1928,  
and that death occurred, on the date stated above, at 2<sup>20</sup> p. m.  
The CAUSE OF DEATH\* was as follows:

Typhoid fever

Cellulitis, both forearms (duration) 6 ds.  
CONTRIBUTORY (Secondary) Lobes pneumonia

right lung (duration) yrs. mos. 2 ds.

18 Where was disease contracted  
if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Widal

(Signed)

Allen Blaisdell

M. D.

19 (Address)

The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

St Michael Mch

20 UNDERTAKER

M. E. Larson

April 22 1928

ADDRESS

844 W 37th

# 33/32 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 S. Parkin ST. 18-76 WARD)

2-FULL NAME John B. Polley

(a) RESIDENCE NO. 129 S. Parkin ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

Now long in U. S., if of foreign birth?

REGISTERED NO. 33132  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary J. Polley

6 DATE OF BIRTH (month, day, and year) Sept 3, 1875

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

52

7

16

8 OCCUPATION OF DECEASED,

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Box street cleaning

(c) Name of employer

Leopoldus

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John B. Polley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary E. Lantier

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Mrs. Mary Polley  
129 S. Parkin St.

15

Filed

22 1928

to

HARVEY JOHNS

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1928

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1924, to April 19, 1928, that I last saw him alive on April 19, 1928, and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH\* was as follows:

Organic Heart Disease

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown (duration) 4 yrs. 9 mos. — da.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & sputum (Signed) Chester Riland, M. D.

4-20, 1928 (Address) 2532 Edmondson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Catholic Cemetery

DATE OF BURIAL

April 25, 1928

20 UNDERTAKER

John J. Bowan & Son

ADDRESS

401 N. Holliday

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33133

## CERTIFICATE OF DEATH

REGISTERED NO.

90 E 33133

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1923 Harlem Ave* St. *4027* Ward)2-FULL NAME *M Elizabeth Rupp*(a) RESIDENCE NO. *1923 Harlem Ave* St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

*Female White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Feb-29-1908*

7 AGE

Years

Months

Days *21*

IF LESS than 1 day..... hrs. or min..

*20**1**22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

 *stenographer*

9 BIRTHPLACE (city or town) (State or country)

*Balto Md.*

10 NAME OF FATHER

*Robert Rupp*

11 BIRTHPLACE OF FATHER (City or town) (State or country)

*Balto Md.*

12 MAIDEN NAME OF MOTHER

*Marie Brown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto Md.*

14

Informant

(Address)

*Mr. R. R. Rupp*  
*1923 Harlem Ave*

15 Filed

, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4-20-1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 1, 1928, to April 20, 1928.*that I last saw her alive on *April 20, 1928.*and that death occurred, on the date stated above, at *11:55 P.M.*

The CAUSE OF DEATH\* was as follows:

*Mitral insufficiency*

CONTRIBUTORY (Secondary)

(duration) *Unknown* yrs. mos. ds.(duration) \_\_\_\_\_ yrs. mos. *2* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed)

, 19

(Address)

*W. B. Byers* M. D.  
*1405 Edmondson Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Louisa Park**4-23-1928*

20 UNDERTAKER

ADDRESS

*Mrs. Chas. G. Rohde* *2327 Edmondson Ave.*

Very important. See instructions on back of certificates.



E 33134

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1251 Carroll

2-FULL NAME Michael Pfister

(a) RESIDENCE NO. 1251 Carroll

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds.

St. Ward

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filed

19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended, deceased from 4/10/1928, to 4/20/28, 19 that I last saw h. alive on 5/10/19

and that death occurred, on the date stated above, at 5:10 p.m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33135

## CERTIFICATE OF DEATH.

74-001  
E 33135

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bon Secours Hosp.* 70-28 ST. WARD)2-FULL NAME *Huriette Kearney*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. *1925 W Balto*

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Patrick Kearney*6 DATE OF BIRTH (month, day, and year) *Dec. 28 1966*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*61 4 1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Rudolph Seibert*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *?*

14

Informant (Address) *Patrick Kearney 1925 W Balto St*

15

Filed

R 23 1928

16

H. J. Jones, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-22-28*

17

I HEREBY CERTIFY, That I attended deceased from *Apr 11*, 19*28*, to *Apr 22*, 19*28*, that I last saw her alive on *Apr 22*, 19*28*, and that death occurred, on the date stated above, at *2:17 A* m.

The CAUSE OF DEATH\* was as follows:

*Arterio Sclerosis Cerebral Hemorrhage*(duration) yrs. mos. *11* ds.CONTRIBUTORY (Secondary) *Same*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *George O Eaton*, M. D., 19 (Address) *Bon Secours Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Cathedral Cmn*

DATE OF BURIAL

*4-25-28*

20 UNDERTAKER

*E & B Hauls 115 E West St*

ADDRESS

33136

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33136

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balt. Sec. 7-48* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Prudence R Gardner*(a) RESIDENCE NO. *440 Wrenwood Ave.* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *25* yrs. mos. ds.

WARD

(If non-resident give city or town and State)

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*William B Gardiner*6 DATE OF BIRTH (month, day, and year) *Don't know*

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs. or min.

*61*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Md.*10 NAME OF FATHER *Dunker*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*12 MAIDEN NAME OF MOTHER *Fisher*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

14

Informant (Address)

*Mrs M. B. Buphman 424 Polaris Ave*

15

Filed

*R. M. JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 21 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr 12 1928* to *Apr 21 1928*that I last saw him alive on *Apr 21 1928*and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH\* was as follows:

*Encephalitis lethargica*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*Myocardial Failure*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *William W. Chase M.D.*, 19 (Address) *South Balt. Sec. 7-48*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*St Anns Cemetery*

DATE OF BURIAL

*Apr 23 1928*

20 UNDERTAKER

*Robt. J. Turner*

ADDRESS

*1314 1/2 W. 1st St.*

E 33137

## HEALTH DEPARTMENT—CITY OF BALTIMORE

11-007E 33137

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *19 N. Fullan St.* ST. *19-28* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *19 N. Fullan St.* ST. *19-28* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*7*

4 COLOR OR RACE

*W.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*John Murphy*

6 DATE OF BIRTH (month, day, and year)

*Dec 5-1886*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

*61**4**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*John Hagerly*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Mary Ward*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

14

Informant (Address)

*Mary O'Neil 19 N. Fullan St.*

15

Filed

1928

*H. JONES, M. D. Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 8*, 19*28*, to *April 20*, 19*28*, that I last saw her alive on *April 20*, 19*28*, and that death occurred, on the date stated above, at *5:10* m. The CAUSE OF DEATH\* was as follows:

*Influenza - 12 days*  
*Chronic pneumonia*

(duration) *4* yrs. *4* mos. *4* ds.CONTRIBUTORY *Acute Dehydration of Heart* (Secondary)(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Edw. H. Hagerly*, M. D., 19 (Address) *19 N. Fullan St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Cathedral Cem.**Apr. 23, 1928*

20 UNDERTAKER

ADDRESS

*Margaret J. Flynn**1420 Light St.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33138

## CERTIFICATE OF DEATH.

E 33138

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *2921 Endman Ave* St., *8-45* Ward)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) Residence No. *2921 Endman Ave* St., *8-45* Ward (If non-resident give city or town and State)Length of residence in city or town where death occurred yrs. mos. *3* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*male*

4-COLOR OR RACE,

*white*6-Single, Married, Widowed, or Divorced, (Write the word.) *single*

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) *April 19 1928*

7-AGE,

yrs. mos. *3* ds. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) *Balto Md* (State or Country),

PARENTS.

10-NAME OF FATHER, *Kenneth M Leonard*11-BIRTHPLACE OF FATHER (city or town) *Beals Island Md* (State or Country),12-MAIDEN NAME OF MOTHER, *Jenna M Tyler*13-BIRTHPLACE OF MOTHER (city or town) *Chesapeake Md* (State or Country),14- (Informant) *Kenneth M Leonard* (Address) *2921 Endman Ave*

15-

FILE

23 1928

H. JONES, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *April 22 1928*17- I HEREBY CERTIFY, That I attended deceased from *April 19*, 19 *28*, to *April 22*, 19 *28*, that I last saw him alive on *April 21*, 19 *28*, and that death occurred, on the date stated above, at *9 a. m.*

The CAUSE OF DEATH\* was as follows:

*Congenital Malformation (cardiac)*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death? *no* Date of.....Was there an autopsy? *none*What test confirmed diagnosis? *none*(Signed) *B. P. Herzig M.D.*Apr 22, 1928 (Address) *1305 N Patterson Pl Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL *Beals Island* DATE OF BURIAL *Apr 24 28*20-UNDERTAKER *R. J. Webster* ADDRESS *Beals Island*



-E 33140 HEALTH DEPARTMENT—CITY OF BALTIMORE

-E 33140

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 3310 Carlisle Ave. 15-61 WARD)

2. FULL NAME Rachael Virginia Sindall

(a) RESIDENCE No. 3310 Carlisle Ave. ST.

Length of residence in city or town where death occurred 64 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (X) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23, 1863

7 AGE Years 64 Months 3 Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Shepherd Legum Sindall

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ann Duncas

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City (State or country) Md.

14 Informant Mrs. Olive P. Dawkins (Address) 3310 Carlisle Ave.

15 R 23 1928 HANSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1928

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1928, to April 20, 1928, that I last saw him alive on Apr. 19, 1928, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH\* was as follows:

Rheumatoid Arthritis

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos. ds.

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

there an autopsy? No

What test confirmed diagnosis?

(Signed)

Apr 22 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 33141 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33141

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE, (No. 3812 Dwyne Oak Ave. ST. 11 WARD)

## 2. FULL NAME

William Henry Bryan

## (a) RESIDENCE No.

3812 Dwyne Oak Ave.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

30

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed or divorced HUSBAND of or WIFE of

Barbara Bryan

## 6 DATE OF BIRTH (month, day, and year)

Jan. 9, 1870

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

3

13

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Paper Hanger

## (b) General nature of industry, business, or establishment in which employed (or employee)

Self

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Annapolis Co. Md.

## 10 NAME OF FATHER

Richard Bryan

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

## 12 MAIDEN NAME OF MOTHER

Emily Burch

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

## 14

Informant (Address)

Mrs. Emma Jordenberg 3904 Dwyne Oak Ave.

## 15

Filed

PR 23 1928

M. J. HANSON JONES, Jr. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22 1928

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to April 22, 1928, that I last saw him alive on April 21, 1928,

and that death occurred, on the date stated above, at 9.45 a.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos. 2 ds.

## CONTRIBUTORY (Secondary)

Carcinoma of Stomach

(duration) 1 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 31-1927

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. &amp; Section

(Signed) Geo. B. Jones, M. D.

19 (Address) 2224 W. North St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Brimed Ridge Cem.

## DATE OF BURIAL

Apr 25, 28

## UNDERTAKER

Wm. McKee Jones

## ADDRESS

North St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33142

## CERTIFICATE OF DEATH.

129-E 33142

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Little Sisters of the Poor* St. *10-14* Ward)2-FULL NAME *William J. Bowen*(a) RESIDENCE NO. *Preston & Valley* St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred *50* yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 Color or Race *W* 5 Single, Married, Widowed, or Divorced. (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
*76*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) *Buffalo, N.Y.*  
(State or country)10 NAME OF FATHER *William Bowen*11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country)12 MAIDEN NAME OF MOTHER *Ellen Slater*13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country)14 Informant *Little Sisters of the Poor*  
(Address) *Preston & Valley St.*15 Filed *23 1928* 19 *HARRY JONES* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *4/18* to *4/20*, 19 *28*, that I last saw him alive on *4/20*, 19 *28*, and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH\* was as follows:

*Chor. Sarcinomatous Nephritis*  
*Unknown* (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY (Secondary) \_\_\_\_\_  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) *Dr. Blumenthal*, M. D.  
*4/21/28* (Address) *914 E. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*Cathedral**Apr. 23, 1928*

20 UNDERTAKER

ADDRESS

*Bela Friedfeld 914 Green St.*

## HEALTH DEPARTMENT - CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33143  
1-PLACE OF DEATHCity of BALTIMORE: (No. *118002* St. *26-37* Ward *1*)2-FULL NAME *Mrs. Stephanie Quick*(a) RESIDENCE NO. *208 A Third*

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F*4 Color or Race *W*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Harry Belmont Quick*6 DATE OF BIRTH (month, day, and year) *4-23-1895*

7 AGE

Years *32*Months *6*Days *27*

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *New York City*10 NAME OF FATHER *Martin Paul*

11 BIRTHPLACE OF FATHER (City or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Not Known*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Germany*

14

Informant (Address) *Hospital records*15 Filed *23 1928*

16 C. H. JONES, M. D. Registrar

REGISTERED NO.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/22/28*

19

17

I HEREBY CERTIFY, That I attended deceased from *4/22/28* to *4/22/28*, that I last saw him alive on *4/22/28* 19and that death occurred, on the date stated above, at *5:50 P.M.*

The CAUSE OF DEATH\* was as follows:

*Myocardial infarction*

CONTRIBUTORY

(Secondary) *Obstruction*

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *No* Date of *7/29/28*Was there an autopsy? *Yes*What test confirmed diagnosis? *Clinical & Autopsy*(Signed) *J. H. Thompson* M. D.19 (Address) *157 E. Pratt St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33144

## CERTIFICATE OF DEATH.

E 33144

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Garrison Lane St. 40 Ward)2-FULL NAME Charles Maucke(a) RESIDENCE NO. 1906 H. Lee St.  Ward 

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 Color or Race W. 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6, 18997 AGE Years 29 Months 2 Days 13 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

## 15 Filled

16

C. H. HARRISON JONES, M. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 192817 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest (Inquest, au-topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY

(Secondary)

april 9 1928 (duration) 1 yrs. 1 mos. 1 ds. (Signed) C. J. Pilepoy (Coroner) M. D.(Address) 43 W. 3rd St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR Date of Burial

REMOVAL

## 20 UNDERTAKER

ADDRESS

E 33145

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* 16-37)2-FULL NAME *Wm. H. Haying*(a) RESIDENCE No. *212 South 6 St.*(Usual place of abode)  
Length of residence in city or town where death occurredST. *Brooklyn* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day... hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

23-1928

How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 22, 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 21, 1928*, to *April 22, 1928*, that I last saw her alive on *April 21, 1928*, and that death occurred, on the date stated above, at *3:00 a. m.* The CAUSE OF DEATH\* was as follows:*Primary Bronchopneumonia*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4-22, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33147  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2030 Robb ST. 9-46 WARD)

2-FULL NAME Mary T. Brown

(a) RESIDENCE NO. 2030 Robb

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs.

mos.

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Charles T. Brown

6 DATE OF BIRTH (month, day, and year)

June 14, 1881

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

46

10

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Domestic

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER

John Wedekind

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant  
(Address)Charles T. Brown  
2030 Robb St.

15

Filed

R 23 1928

R 23

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 19 28

17

HEREBY CERTIFY, That I attended deceased from

Mich S. 19 28 to Sep 20 19 28

that I last saw deceased on Sep 20 19 28

and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Lungs

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

4/21, 1928 (Address)

G. W. Brown

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVING

DATE OF BURIAL

London Park Apr. 23 19 28

20 UNDERTAKER

ADDRESS

Mr &amp; Mrs John W. Deufel &amp; Son 801 N. Fayette

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33148

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 16-68 Ward)2-FULL NAME Alice Jane Roloff(a) RESIDENCE NO. 2305 Riggs Avenue St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Theodore E. Roloff (or) WIFE of Theodore E. Roloff6 DATE OF BIRTH (month, day, and year) December 7, 18727 AGE Years 55 Months 4 Days 14 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer At Home9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER Joseph Dunkerly11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland12 MAIDEN NAME OF MOTHER Laura B. Jones13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) Cumberland, Md.14 Informant Theodore E. Roloff (Address) 2305 Riggs Avenue15 Filed 23-1928 19 \_\_\_\_\_ C. H. JONES, Jr.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1928 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said \_\_\_\_\_ (Inquest, autopsy or inquiry.)

and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral HemorrhageCONTRIBUTORY Caution (Secondary) \_\_\_\_\_4/22/28 (Signed) Geo. Clinton B. Jones (Coroner) M. D.(Address) 149 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Apr. 24, 192820 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. ...

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33149

## CERTIFICATE OF DEATH

129 E 33149

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Linden St. 14-20 Ward)

## 2-FULL NAME

Mary Ann Doyle

## (a) RESIDENCE NO.

1412 Linden St.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

white

## 5 Single, Married, Widowed, or Divorced; (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

November 3<sup>rd</sup> 1869

## 7 AGE

58

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

59

4

18

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Housework

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Maryland

## 10 NAME OF FATHER

Michael Doyle

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Mary Dingley

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

## 14

Informant (Address)

Mrs. Catherine Skelton 1412 Linden St.

## 15 Filed

23 1928

J. J. JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 21<sup>st</sup> 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

April 20, 1928, to April 21, 1928,

that I last saw her alive on April 21, 1928,

and that death occurred, on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH\* was as follows:

Hypertension  
Myocarditis

(duration) yrs. mos. 1 da.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 da.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine

(Signed) Thos. J. A. Sevens, M. D.

4/21, 1928 (Address) 2878 Hampden Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. James Cemetery, Long Green, Md. April 24, 1928  
TO UNDERTAKER John C. Mitchell & Sons 1900 Eutaw Place.



E 33150

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33150

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3420 Mt. Pleasant Ave. ST

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Elizabeth Ann Sanders

(a) RESIDENCE No. 3420 Mt. Pleasant Ave. ST.,

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 94 yrs. 9 mos. 28

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John F. Sanders

6 DATE OF BIRTH (month, day, and year) June 23, 1833

7 AGE

Years 94

Months 9

Days 28

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

10 NAME OF FATHER John Hubbard

11 BIRTHPLACE OF FATHER (city or town) Md.

12 MAIDEN NAME OF MOTHER Rebecca Mahaney

13 BIRTHPLACE OF MOTHER (city or town) Md.

14 Informant Mrs. Lillie Ely (Address) 3420 Mt. Pleasant Ave.

15 Filed R 23 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20, 19 28

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to April 20, 1928, that I last saw her alive on April 18, 1928, and that death occurred, on the date stated above, at 1.10 p. m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Titlow, M. D.

4/20, 1928 (Address) 315 S. Highland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Baltimore Cemetery

April 23, 1928

7.5 Light St

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

212903  
E 33151

## CERTIFICATE OF DEATH.

74 E 33151

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

10

yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced. (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant  
(Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 7, 1928, to April 19, 1928,

that I last saw her alive on April 19, 1928,

and that death occurred, on the date stated above, at 5<sup>00</sup> P.M. m.

The CAUSE OF DEATH\* was as follows:

Degenerated Myometrium uteri

(duration) ? yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? yes Date of 4.19.28

Was there an autopsy? No

What test confirmed diagnosis? Laparotomy

(Signed) Robert J. Faust, M. D.

4.19.1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33152

## CERTIFICATE OF DEATH.

90 E 33152

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1935 Bunt ST. 14-20 WARD)

## 2. FULL NAME

Sarah Catherine High

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1935 Bunt ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of James High6 DATE OF BIRTH (month, day, and year) 18727 AGE Years 56 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Talbot Co Md  
(State or country)10 NAME OF FATHER Adam Kirby11 BIRTHPLACE OF FATHER (city or town) Talbot Co Md  
(State or country)12 MAIDEN NAME OF MOTHER Elyzabeth Sullivan13 BIRTHPLACE OF MOTHER (city or town) Talbot Co Md  
(State or country)14 Informant Ethel Curtis  
(Address) 1912 Pa Ave15 Filed 23 1928 Registrar C. H. Jones

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1928

17

I HEREBY CERTIFY, That I attended deceased from Mar 6 1928 to Apr 20 1928, that I last saw her alive on Mar 5 1928and that death occurred, on the date stated above, at 12.55 m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease(duration) 2 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Fry, M. D.\*21. 1928 (Address) 1928 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

BURYAL

St. Chubb's Church4/23/28

FUNERAL

ADDRESS 578Samuel Hensley

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33153

## CERTIFICATE OF DEATH

75-001  
E 33153  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1423 N. Broadway St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 1423 N. Broadway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. - mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced  
HUSBAND of Anna Conroy  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Not known

## 7 AGE

Years

Months

Days

68

IF LESS than  
1 day - hrs.  
or - min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Iron Moulder

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Michael Conroy

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Annora Butler

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

## 14

Informant

(Address)

Mrs. Nellie Wagner  
1423 N. Broadway

## 15 Filed

16

H. J. Jones, Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

## 17

I HEREBY CERTIFY, That I attended deceased from

4-7, 1928, to 4-22, 1928

that I last saw her alive on 4-22, 1928

and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Hemiplegia

(duration) yrs. mos. 15 ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Daniel Miller, M. D.

4/22, 1928 (Address) 1500 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

New Cathedral Cemetery. Apr. 25, 1928

## 20 UNDERTAKER

ADDRESS

Conroy &amp; Sons, 1500 N. Broadway



E 33154

## HEALTH DEPARTMENT—CITY OF BALTIMORE—E 33154

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balti City Hospital 26-37* WARD)2-FULL NAME *Mary Haas*(a) RESIDENCE NO. *5055 Odumell*(Usual place of abode)  
Length of residence in city or town where death occurred *Life* mos.ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(If non-resident give city or town and State)  
How long in U. S., If of foreign birth? yrs. mos. ds.REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Andrew Haas*6 DATE OF BIRTH (month, day, and year) *Jan 31/70*7 AGE Years Months Days *58 - 2 22* If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *at Home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Geo Albert*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Mary*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant (Address) *Andrew Haas 5055 Odumell St*15 Filed *23 1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-22 1928*17 I HEREBY CERTIFY, That I attended deceased from *4-11*, 19*28*, to *4-22*, 19*28*that I last saw him alive on *4-22*, 19*28*and that death occurred, on the date stated above, at *2:45* m.The CAUSE OF DEATH\* was as follows:  
*uterine prolapse*CONTRIBUTORY (Secondary) *Coronary Embolism* (duration) *2 yrs.* mos. ds.18 Where was disease contracted if not at place of death? *Sweden death* (duration) *same*Did an operation precede death? *yes* Date of *4-13-28*Was there an autopsy? *no*What test confirmed diagnosis? *Physical findings*(Signed) *W. L. G. M. D.*19 (Address) *Balti City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL *St. Carmel*20 UNDERTAKER *Philip Henry*

DATE OF BURIAL

*4/26 1928*ADDRESS *2016 Adams St*

E 33155

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33155

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3724 Morley* ST., *20-70* WARD)2-FULL NAME *Esther W. W. Warden*(a) RESIDENCE NO. *3724 Morley St* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed,

or Divorced (write the word)

*Single*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Mar 12 1928*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*1**9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*none*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md.*

10 NAME OF FATHER

*Wm. E. Warden*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Balto Md.*

12 MAIDEN NAME OF MOTHER

*Esther W. Warden*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balto Md.*

14

Informant  
(Address)*Wm. E. Warden  
3724 Morley St.*

15

Filed

*23 1928* REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April-21 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb-24-1928* to *April-21 1928*that I last saw her alive on *April 21 1928*and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumo-Pneumonia*(duration) yrs. *00* mos. *1* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*S. Lloyd Johnson M.D.*

, 19

(Address)

*4200 Frederick St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

*New Cathedral*

DATE OF BURIAL

*April 23, 1928*

UNDERTAKER

*E. W. Dill*

ADDRESS

*3724 Morley St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33156

## CERTIFICATE OF DEATH.

90 E 33156

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1225 Poplar Grove 16-68 Ward)2-FULL NAME Emma Hanitsch(a) RESIDENCE NO. 1225 Poplar Grove Ward

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of Adam Hanitsch (or) WIFE of6 DATE OF BIRTH (month, day, and year) Mar 31 - 18577 AGE Years 77 Months 21 Days 20 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Anthony Haber11 BIRTHPLACE OF FATHER (city or town) Europe (State or country)12 MAIDEN NAME OF MOTHER Margaret Miller13 BIRTHPLACE OF MOTHER (city or town) Europe (State or country)14 Informant Mary Denehy (Address) 1225 Poplar Grove15 Filed APR 23 1928 Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest (Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis (duration) 1 yrs. 7 mos. 7 ds.

## CONTRIBUTORY (Secondary)

(Signed) J. B. Link M. D.(Address) Apr 21 - 1928

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

place In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial April 2420 UNDERTAKER B. W. DillADDRESS 8109 Fredk. Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33157

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 33157

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital 2037 St. 2037 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 114 N - 5th

(Usual place of abode)

Length of residence in city or town where death occurred

5 yrs. 8 mos. 18 ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

August 2-1922.

## 7 AGE

Years

5

Months

8

Days

18

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workChild,  
SMITH(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore, MD.

(State or country)

Frank Frederick,

## 10 NAME OF FATHER

Frank Frederick,

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Italy,

## 12 MAIDEN NAME OF MOTHER

Teresa Stacharowski

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, MD.

## 14

Informant  
(Address)Frank Frederick, (Father)  
114 S. Eight Street

## 15

Filed

APR 23 1928

J. J. JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr 20 1928

## 17

I HEREBY CERTIFY that I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)Thereon and from the evidence obtained I said  
(Inquest, autopsy or inquiry.) and that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Auto. Acc.,  
Multiple FracturesCONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

1 hr

(Signed) Geo. B. Brady

(Coroner)

1 hr

(Address) 43 W. Bray

(Coroner)

M. D.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

ST. STANISLAUS CEMETERY,

Date of Burial

Apr. 23 1928

## 20 UNDERTAKER

M. J. Andowicki..

ADDRESS  
705 S. Ann St



E 33158

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001  
E 33158  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *2* WARD)2-FULL NAME *Joanna C. Van Rossum*(a) RESIDENCE NO. *4025 Parkside Drive*  
(Usual place of abode)Length of residence in city or town where death occurred *1* yrs. *0* mos. *0* ds.

WARD

(If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Sept 22, 1925*

7 AGE

Years *2*Months *7*Days *0*If LESS than  
1 day. hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Balt*  
(State or country)  *Md.*10 NAME OF FATHER *Harry E. Van Rossum*11 BIRTHPLACE OF FATHER (city or town) *Balt*  
(State or country)  *Md.*12 MAIDEN NAME OF MOTHER *Lena P. P. P.*13 BIRTHPLACE OF MOTHER (city or town) *Balt*  
(State or country)  *Md.*Informant *Harry E. Van Rossum*(Address) *4025 Parkside Drive*Filed *23 1928*Registrar *W. H. Jones*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/22/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *4/4/28*, 19, to *4/22/28*, 19.that I last saw her alive on *4/22/28*, 19.and that death occurred, on the date stated above, at *12:45 P.* m.

The CAUSE OF DEATH\* was as follows:

*Tracheo pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY *cardiac dilatation*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *A. Lawrence Zahner*, M. D., 19 (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Parkwood Cemetery*

20 UNDERTAKER

*Henry Sander & Sons Inc*

DATE OF BURIAL

*Apr. 25, 1928*

ADDRESS

*1710 Fleet St.*

E 33159

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 33159

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 Roland Ave

ST. 13-52 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Mary M. Joice

(a) RESIDENCE No. 3503 Roland Ave

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Joice

6 DATE OF BIRTH (month, day, and year) April 23, 1883

7 AGE 75

Years

Months 11

Days 29

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Lewis A. Timpane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

4 Informant (Address) John E. Baublitte

5

Filed

19

JONES R. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1928

1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 1st, 1928, to Apr 22nd, 1928, that I last saw her alive on Apr 21st, 1928, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis and Uremia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

4/23/28 (Address) 846 W 36th St

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 33160

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33160

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2921 Cedar Ave ST. 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Catherine Eloise Harding(a) RESIDENCE NO. 2921 Cedar Ave ST. 13-52 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleWhiteSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11, 1908

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

1989

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Candy makingFannie MayCandy Co.

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Fannie M. Harding  
2921 Cedar Ave

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1928

17

I HEREBY CERTIFY, That I attended deceased from June 7, 1927, to April 20, 1928, that I last saw her alive on April 20, 1928, and that death occurred, on the date stated above, at 10:30 m. The CAUSE OF DEATH\* was as follows:

Cardiac Exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Signs(Signed) J. H. Munch, M. D., 19 (Address) 4037 Falls Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Cem.April 23, 1928

20 UNDERTAKER

ADDRESS

Chenoweth4037 Falls Rd.

PR 23 1928

HARRISON JONES, M. D.  
Registrar

E 33161

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1008 Argyle Ave St. 17-24 Ward)2-FULL NAME Louise Gross(a) RESIDENCE NO. 1008 Argyle Ave St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

REGISTERED NO.

3340

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 Color or Race

C.C.

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1873

7 AGE

Years

55

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Calvert Co Md

(State or country)

10 NAME OF FATHER

Wm Gross

11 BIRTHPLACE OF FATHER (city or town)

Calvert Co Md

(State or country)

12 MAIDEN NAME OF MOTHER

Mary Gross

13 BIRTHPLACE OF MOTHER (city or town)

Calvert Co, Md

(State or country)

14

Informant (Address)

Sister Mrs Christine Gutchard 1920 Kater St. Phila Pa

15

Filed

C. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 21,

1928

17

I HEREBY CERTIFY, That I attended deceased from

April 9, 1928, to April 21, 1928,

that I last saw her alive on April 21, 1928, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH was as follows:

Chronic Valvular Heart Disease and Chronic Interstitial Nephritis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Uræmia

(Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of.....Was there an autopsy? noWhat test confirmed diagnosis? Physical Exam(Signed) Wm H. Frazier, M. D., 19 (Address) 138 W Hill St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Not Auburn Cemetery April 23, 28

UNDERTAKER

ADDRESS 322

Mrs. Kate R Williams N. E. Schuyler



2/3/18  
E 33162

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001 ✓  
E 33162

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO. \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 CITY OF BALTIMORE: (No. 46-1 ST., WARD)  
 2-FULL NAME Charles Glasch  
 (a) RESIDENCE No. 1122 S-1<sup>st</sup> ST., 26 WARD City  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-6-27  
 7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
5 14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind -  
 (State or country)

10 NAME OF FATHER Charles A. Glasch

11 BIRTHPLACE OF FATHER (city or town) Ind -  
 (State or country)

12 MAIDEN NAME OF MOTHER Margaret Hyman

13 BIRTHPLACE OF MOTHER (city or town) Ind -  
 (State or country)

14 Informant Dr. C. A. Glasch  
 (Address)

15 Filed 23 1928 RECEIVED JOHN HOPKINS HOSPITAL  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1928

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1928, to April 20, 1928,  
 that I last saw him alive on April 20, 1928,  
 and that death occurred, on the date stated above, at 11 10 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY Otitis media  
 (Secondary)

(duration) yrs. mos. 11 ds.

18 Where was disease contracted  
 if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Allen Blouman, M. D.

, 19 (Address) The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Sacred Heart Cemetery

April 23 1928

20 UNDERTAKER

ADDRESS

Kelly & Jones Inc.

4022 W. 1st St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33163

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 33163

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2925 Eastern St. 1 Ward 1)2-FULL NAME Beatrice E. Quinn(a) RESIDENCE NO. 2925 Eastern St. 1 Ward 1

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

c DATE OF BIRTH (month, day, and year)

Sept. 16 1926

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

1

7

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

10 NAME OF FATHER Raymond J. Quinn

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER Winnie Robertson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto. Md.

14

Informant Raymond J. Quinn  
(Address) 2925 Eastern Ave.

15

16 DATE OF DEATH (month, day, and year) April 22 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

April 22

17

I HEREBY CERTIFY, That I attended deceased from

March 29, 1928, to April 22, 1928,

that I last saw him alive on

April 22, 1928,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumo - Pneumonia + Strep. Hem.

Supp. -

(duration) yrs. 1 mos. ds.

CONTRIBUTORY Convulsions

(Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? —(Signed) Thos. B. Smith, M. D.

19

(Address)

125 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Boni Brae Cem.

Apr. 23 1928

20 UNDERTAKER

ADDRESS

Lilly &amp; Geiler Inc. 403 S. Wolfe St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33164

## CERTIFICATE OF DEATH.

44 E 33164

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 South Fremont Ave. ST. 18-26 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME Frances Yuskevicius

(a) RESIDENCE No. 36 South Fremont Ave.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 30 yrs. - mos. - ds. How long in U. S., if of foreign birth? 30 yrs. - mos. - ds. (If non-resident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) No. 1860

AGE 68 Years - Months - Days

If LESS than 1 day. hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 30

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Lithuania (State or country)

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) Lithuania (State or country)

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) Lithuania (State or country)

Informant Jul. Monroe (Address) 36 South Fremont Ave

Filed

23 1928

G. H. JONES M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1928

17

I HEREBY CERTIFY, That I attended deceased from Jun. 16, 1928, to 4/20, 1928.

that I last saw him alive on 4/20 1928 and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH\* was as follows:

Calcium of Liver

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed)

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer April 24, 1928

UNDERTAKER

ADDRESS

John Gebliancas 423-3 Paca St.

E 33165

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33165

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bon Secours* ST., *15* WARD)2. FULL NAME *Jennie A. Farley*(a) RESIDENCE No. *3903 - 1st St. W.* ST., *15* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND or (or) WIFE of *Augustine Farley*6 DATE OF BIRTH (month, day, and year) *Feb 20 1882*

7 AGE

Years *46*Months *2*Days *—*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *—*(c) Name of employer *—*BIRTHPLACE (city or town) (State or country) *Balto. Md*10 NAME OF FATHER *Frank Schuler*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto. Md*12 MAIDEN NAME OF MOTHER *Grace Blanch*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto. Md*Informant *Mr. Grace Blanch*(Address) *3903 - 1st St. W.*

Filed

19

Registrar *K. M. C.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 20 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr. 4*, 1928, to *Apr. 20*, 1928,that I last saw her alive on *Apr. 20*, 1928,and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH\* was as follows:

*Myocarditis Chronic*(duration) *4* yrs. mos. ds.CONTRIBUTORY *Pneumonia, Basal* (Secondary)(duration) *16* yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *At home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *George O Eaton*, M. D., 19 (Address) *Bon Secours Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Trinity Cemetery* DATE OF BURIAL *Apr 22 1928*20 UNDERTAKER *H. B. Weyant*ADDRESS *150 N. Balto St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33166

## CERTIFICATE OF DEATH

REGISTERED NO.

E 33166

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *118-002* St. *21-29* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Joe Klein*(a) RESIDENCE NO. *1400 S. Larry* St. *21* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *23* yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 Color or Race *W*5 Single *Married*, Widowed, or Divorced, (write the word)

16 DATE OF DEATH (month, day, and year)

19

5a If married, widowed, or divorced  
HUSBAND of *wife*  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days *21*IF LESS than  
1 day hrs.  
or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Piano factory*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *Russia*10 NAME OF FATHER *Joe Klein*

11 BIRTHPLACE OF FATHER (City or town)

(State or country) *Russia*12 MAIDEN NAME OF MOTHER *Goldine Roschard*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Russia*

14

Informant  
(Address) *Hosp. Records*

15 Filed

19

File

Registrar

## MEDICAL CERTIFICATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

*4-17-28* 19*28*, to *4-23-28* 19that I last saw him alive on *4-23-28* 19and that death occurred, on the date stated above, at *2:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Internal Hemorrhage*

CONTRIBUTORY

(Secondary)

(duration)

Yrs. *7*

mos.

ds.

(duration)

yrs.

mos. *6*

ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *No*Date of *4/17/28*Was there an autopsy? *No*What test confirmed diagnosis? *Chemical*(Signed) *Joe Klein*

19

(Address) *118-002 St. 21-29*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

REMOVAL

Date of Burial

*St. Paul's Catholic Church* *Apr 25 1928*

20 UNDERTAKER

ADDRESS

*1850 N. Baltimore St.*

E 33167 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33167

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1621 Palapen* ST. *23-34* WARD)2-FULL NAME *Richard J. Dodson*(a) RESIDENCE. No. *1621 Palapen* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *21* mos. *21* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 1/1927*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *1* *21*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*10 NAME OF FATHER *Thomas Dodson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Pa*12 MAIDEN NAME OF MOTHER *Fannie Davis*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Pa*14 Informant (Address) *Thomas Dodson 1621 Palapen*15 Filed *PR 23 1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 22 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 15 1928* to *April 22 1928* that I last saw him alive on *April 22 1928*and that death occurred, on the date stated above, at *12:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Ripid Spine*

CONTRIBUTORY (Secondary)

(duration) *Life* yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chemically*(Signed) *R. B. Campbell* M. D. (Address) *1644 Hancock*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mt. Olivet*

DATE OF BURIAL

*4/24/1928*

20 UNDERTAKER

*William Cook*

ADDRESS

*502 E. North Ave.*

See Letter in file from Dr. J. H. Potter Coroner

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33168

## CERTIFICATE OF DEATH.

185 E 33168

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1217 N. Washington St. St. 8-13 Ward)

2-FULL NAME Emanuel R. Frey

(a) RESIDENCE NO. 1217 N. Washington St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Frey

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 79 75 Months 11 Days 21 May 1/1851 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Glen Rock, Pa.

10 NAME OF FATHER Jacob Frey

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pa

12 MAIDEN NAME OF MOTHER May Rohrbaugh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pa.

14

Informant (Address)

Mary A. Frey

1217 N. Washington St.

15

Filed 1928 C. 4/23/28 JONES R.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

193

Apr 22/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Shock-probable contusion of brain. Accidentally fell out of 2nd story window of residence.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

(Address)

4/23/28 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Parkwood

4/24 1928

20 UNDERTAKER

ADDRESS

William Cook

508 E. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33169

## CERTIFICATE OF DEATH

45 E 33169

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4615 Bellview St., 28-263 Ward)

## 2-FULL NAME

Julia E. Crutchley

## (a) RESIDENCE NO.

4615 Bellview St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 Color or Race

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward S. Crutchley

6 DATE OF BIRTH (month, day, and year)

Feb 12, 1858

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

70

2

10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md

10 NAME OF FATHER

J. M. Morris

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

J. E. Crutchley 4615 Bellview St.

15 Filed

G. HANSON JONES, Jr. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 22 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr 10, 1926, to Apr 22, 1928.

that I last saw him alive on April 21, 1928.

and that death occurred, on the date stated above, at 6:55 P. M.

The CAUSE OF DEATH\* was as follows:

Cardiac (estimated)

(duration)

10 ds.

CONTRIBUTORY

(Secondary)

(duration)

2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. E. Crutchley

M. D.

4-13, 1928 (Address)

1 E Randall St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Higginson Undertaker

Apr 24 1928

ADDRESS

507 E. 11th St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33170  
PLACE OF DEATH

## CERTIFICATE OF DEATH.

Registered No. C.....

City of BALTIMORE: (No. 400 W. Camden 27-30 Ward)

2-FULL NAME Robert A. Sommerville

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 727 Shepherd St. N. W. Washington, D.C. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male	4-COLOR OR RACE, White	5-Single, Married, Widowed, or Divorced, (Write the word.) Single
6-DATE OF BIRTH, April 12 1984 (Month) (Day) (Year)		
7-AGE, 44 yrs. 0 mos. 8 ds.		8-If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Laborer		
9-BIRTHPLACE, (State or Country). Washington, D.C.		
PARENTS.	10-NAME OF FATHER, O. W. Sommerville	
	11-BIRTHPLACE OF FATHER, (State or Country). W. Va	
	12-MAIDEN NAME OF MOTHER, Unknown	
	13-BIRTHPLACE OF MOTHER, (State or Country). Md	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Charles Houser

(Address) 727 Shepherd St. Wash.

23 1928. HARRY JONES, M. D.

Filed 1928 Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
April 22 1984  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Alcoholism

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed) August 27 1984 M. D.

4/23 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

20-UNDERTAKER. ADDRESS

E 33171

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33171

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at  
City of BALTIMORE: (No. Hopkins St. 5-9 Ward)

2-FULL NAME Frank Kennedy

(a) RESIDENCE NO. 1420 E. Fairmount Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred *see below* ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) divorced

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years Months Days IF LESS than  
55 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town)

(State or country) Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) "

PARENTS

14 Informant Annie Allen  
(Address) 1420 E. Fairmount Ave

15 Filled by *C. H. Allen* 19 *4-23-28* 20 *Christ N. Johnson*

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1928 Apr 21/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry and that said deceased came to his death  
(Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Hemorrhage (from nose & mouth)

Probably Tuberculosis

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(Signed)

(Coroner)

4/23/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death:

Former or usual residence:

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
MEMORIAL

20 UNDERTAKER

ADDRESS

*Asbury Cemetery Apr. 25, 1928*  
*Christ N. Johnson*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33172  
PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10195 Binney ST., 1 WARD)

2-FULL NAME Anna Ratajczak

(a) RESIDENCE NO. 1009 S Binney ST., 1 WARD  
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. - mos. ds. How long in U. S., if of foreign birth? 35 yrs. - mos. - ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887, July 16

7 AGE 51 Years 50 Months 25 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1928

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1928, to April 21, 1928, that I last saw her alive on April 21, 1928,

and that death occurred, on the date stated above, at 1045 pm.

The CAUSE OF DEATH\* was as follows:

Influenza Broncho-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

4/23, 1928 (Address) 203 E. Ratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 33173

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33173

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 828 S Milton Ave St., 13 Ward)

Registered No. ....

## 2-FULL NAME

Steve Urbaniak

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) Residence No.

828 S Milton Ave

(Usual place of abode)

St., 1 Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

6 months

ds.

How long in U. S., if of foreign birth?

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

## 5-Single, Married, Widowed, or Divorced.

Child  
(Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

1927-Sep 5

## 7-AGE,

7 yrs. 17 mos. 17 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country),

Whitcomb Md

## 10-NAME OF FATHER

Stephen Urbaniak

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

Pitt. Pa

## 12-MAIDEN NAME OF MOTHER

Ida Michalak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

Balto Md

## 14-

(Informant) Stephen Urbaniak(Address) 828 S Milton Ave

## 15-

Filed

10

Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

April 22-28

17-

I HEREBY CERTIFY, That I attended deceased from

April 2 1928 to April 22 1928that I last saw him alive on April 21 1928and that death occurred, on the date stated above, at 640 p m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia, following Measles(Duration) yrs. mos. 14 ds.

CONTRIBUTORY Myocardial Insufficiency (Secondary)

(Duration) yrs. mos. 1 1/2 ds.18-Where was disease contracted if not at place of death? CityDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis Physical Signs(Signed) I. B. Bronushas M. D.4-23-28 (Address) 3037 O'Donnell St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL,

St Stanislaus Cem4-24 1928

20-UNDERTAKER

ADDRESS

Stephany FialkowskiShenwood Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33174

E 33174

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 Hamilton Lodge 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Bobbitt(a) RESIDENCE NO. 829 Hamilton Lodge ST.

WARD

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds.How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) Apr. 18, 1876

7 AGE

52 Years5 Months4 Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Rhode Island10 NAME OF FATHER S. R. Bobbitt11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.12 MAIDEN NAME OF MOTHER A. Blandford13 BIRTHPLACE OF MOTHER (city or town) (State or country) Connecticut

14

Informant (Address) J. P. Bobbitt  
Providence R.I.

15

Filed 1928

APR 23 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1928

17

I HEREBY CERTIFY, That I attended deceased from August, 1924, to April 22, 1928, that I last saw him alive on April 21, 1928, and that death occurred, on the date stated above, at 7:30 a. m. The CAUSE OF DEATH\* was as follows:Epilepsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Complication of Epilepsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) S. S. Mott M. D.Address 576 Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Providence R.I.DATE OF BURIAL 4/23/2820 UNDERTAKER W. J. JenkinsADDRESS McBulter

E 33175

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

71-001 E 33175

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital* ST., *7-12* WARD)2-FULL NAME *Frances A. Moran*(a) RESIDENCE NO. *27108 Madison*

(Usual place of abode)

Length of residence in city or town where death occurred *11* yrs. *8* mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *white*5 Single, Married, Widowed, or Divorced, (write the word) *S*6a If married, widowed, or divorced HUSBAND of (or) WIFE of */*7 DATE OF BIRTH (month, day, and year) *Aug - 1916*

8 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *City*10 NAME OF FATHER *William B. Moran*11 BIRTHPLACE OF FATHER (city or town) (State or country) *City*12 MAIDEN NAME OF MOTHER *Madeline Hein*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *City*Informant (Address) *William B. Moran*

Filed

14

15

16

17

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20

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/21/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *4/21/28*, 19 to *4/21/28*, 19, that I last saw her alive on *4/21/28*, 19, and that death occurred, on the date stated above, at *4:45 P.* m.

The CAUSE OF DEATH\* was as follows:

*cerebro-spinal meningitis (pneumococcus)*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *cardiac dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *A. Lawrence Tatum*, M. D.19 (Address) *St Joseph Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS *3000 E. Baltimore*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33176

## CERTIFICATE OF DEATH.

129 E 33176

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2210 - Mace St. 12-51 Ward)2-FULL NAME Foster E Brooks(a) RESIDENCE NO. 2210 - Mace St. 12-51 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of May L. Brooks6 DATE OF BIRTH (month, day, and year) March 22, 18897 AGE 39 Years 29 Months 0 Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Glasters, Va.10 NAME OF FATHER Guy F. Brooks

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Glasters, Va.12 MAIDEN NAME OF MOTHER Sarah B. White

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Glasters, Va.

14

Informant Family Record  
(Address) 2210 Mace St

15

Filed C. HARRISON JONES Registrar  
1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 21, 1928, that I last saw him alive on April 21, 1928, and that death occurred, on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial Nephritis(duration) 6 yrs. 0 mos. 0 ds.

## CONTRIBUTORY

(Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of.....Was there an autopsy? NoWhat test confirmed diagnosis? Autopsy(Signed) L. J. Jones, M. D., 19 1928 (Address) 2329 Guilford

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Glasters Co VaDate of Burial Apr 23, 1928

20 UNDERTAKER

Mrs R A Elliott askland Ave

E 33177

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33177

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *709 N. Calhoun* ST. *16-23* WARD)2. FULL NAME *Rosanna Mc Abbe*(a) RESIDENCE NO. *709 N. Calhoun* ST. *16-23* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *23* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Sam'l M. Abbe*DATE OF BIRTH (month, day, and year) *Jan 1<sup>st</sup> 1892*

AGE Years Months Days

*46**3**20*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *70*

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *D. C.*10 NAME OF FATHER *Benjamin Calhoun*11 BIRTHPLACE OF FATHER (city or town) (State or country) *D. C.*12 MAIDEN NAME OF MOTHER *Caroline Rachel*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *D. C.*Informant (Address) *109 N. Calhoun St.*

1328

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 21 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr. 21*, 19*28*, to *Apr. 21*, 19*28* that I last saw him alive on *Apr. 21*, 19*28* and that death occurred, on the date stated above, at *11 P.* m.

The CAUSE OF DEATH\* was as follows:

*acute congestion of lungs*CONTRIBUTORY (Secondary) *Pulmonary Edema* (duration) yrs. mos. ds. *405 hours*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *C. H. Pigott*, M. D.4/23 1928 (Address) *1536 W. Kanawha St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Home*DATE OF BURIAL *4-23-28*20 UNDERTAKER *Chase, Inc.*ADDRESS *1400 N. ...*



Isabella T. Patterson  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33178

## CERTIFICATE OF DEATH.

74-901  
E 33178  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 E. 30th

ST., 9-46 WARD)

2-FULL NAME Isabella T. Patterson

(a) RESIDENCE NO. 518 E. 30th

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 8 mos. 11 ds.

ST., WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1874

7 AGE Years 53 Months 8 Days 11 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Maryland (State or country)

10 NAME OF FATHER Wm. R. Patterson

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Mary T. Jones

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's Maryland (State or country)

14 Informant Miss Emma E. Patterson (Address) 518 E. 30th Street

15 Filed 3-18-28 C. MATTISON JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21/28

17 I HEREBY CERTIFY, That I attended deceased from 4/21/25, 19 to 4/21/28, 19 that I last saw her alive on 4/18/28, 19 and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows:

Ch. Endocarditis  
Arterio Sclerosis(duration) 4 yrs. mos. ds.  
CONTRIBUTORY (Secondary) Corbue Apoplexy(duration) 4 yrs. mos. 1 ds.  
18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Gardner M. D. 4/23/28 (Address) 321-E-25th

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park Cemetery

DATE OF BURIAL

4/24 19 28

20 UNDERTAKER

Henry H. Mears &amp; Son 805 N. Calver

E 33179

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33179

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *3907 Montgomery an* ST. *28-63*)2—FULL NAME *Charles F. Everhart*(a) RESIDENCE NO. *3907 Montgomery an* ST.

(Usual place of abode)

Length of residence in city or town where death occurred *80* yrs. *22* mos. *22* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Caroline Everhart*

DATE OF BIRTH (month, day, and year)

*March 24, 1848*

AGE

Years

Months

Days

*80**—**22*If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Candy Muffin*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Self*BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*

10 NAME OF FATHER

*Unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Unknown*

Informant

(Address)

*Caroline Everhart*  
*3907 Montgomery an*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 21-1928*

17

I HEREBY CERTIFY That I attended deceased from

*April 18, 1928* to *April 21, 1928*that I last saw him alive on *April 21, 1928*and that death occurred, on the date stated above, at *6:30* m.

The CAUSE OF DEATH was as follows:

*Arterio Sclerosis*  
*(Cerebral Haemorrhage)*CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

R 23 1928

JAMES JONES

JAMES JONES

*Crown Cemetery*  
*Darry W. Ehlert**Apr. 24 1928*  
*1746 W. North an*

E 33180

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 8-45 Ward)

## 2-FULL NAME

John Matassa

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 3345 Belair Road St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

male white single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3/1921

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

6 8 17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Cosimo Metassa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Teresa DiPietra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Father (Address)

15 Filed 1928 C. HARRISON JONES, Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Intracranial Hemorrhage. Fracture of skull Struck by Automobile at Belair &amp; Mayfield Ave

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) J. H. Carter, M. D. (Coroner)

4/23/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

where was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Redeemer April 24 1928

20 UNDERTAKER ADDRESS

Frank V. Ripstone 2818 E. Balto St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33181

## CERTIFICATE OF DEATH

E 33181

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2640 Harlem Ave.

St. 16-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME VIRGINIA FRANK.

(a) RESIDENCE NO. 2640 Harlem Ave

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 23/28

7 AGE

Years

Months

Days

IF LESS than 1 day 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

Md.

10 NAME OF FATHER George Lewis

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Hattie Sweey.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

George Lewis Frank.

2640 Harlem Ave.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/28 1928

17 I HEREBY CERTIFY, That, I, attended deceased from April 23, 1928, to April 23, 1928, that I last saw her alive on April 23, 1928.

and that death occurred, on the date stated above, at 7:30 AM.

The CAUSE OF DEATH\* was as follows:

Morine Asphyxia.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes; Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

1337 S. Charles St.

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

REMOVAL

Holy Cross, A. A. CO

Date of Burial

4/24/28 19

20 UNDERTAKER

Richard W. Meyer 1620 Ashburton St

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33182

## CERTIFICATE OF DEATH

90 E 33182

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2717 Overland Ave. St. 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eberhard H. Lampe

(a) RESIDENCE NO. 2717 Overland Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)  
Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Apalonia.

6 DATE OF BIRTH (month, day, and year)

3/5/1846

7 AGE

Years

Months

Days

82

1

17

IF LESS than  
1 day hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14

Informant

Mr. Leonard Lampe.

(Address)

2717 Overland Ave

15 Filed

3 1928

C. HANCOCK JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 15<sup>th</sup>, 1928, to April 22<sup>nd</sup>, 1928.that I last saw him alive on April 21<sup>st</sup>, 1928.

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Sordy

M. D.

4-22-1928 (Address) 4218 McPherson Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cemetery  
Druid Hill, Park

Date of Burial

4/25/28

19

20 UNDERTAKER

Richard W. Meyer 1620 ADDRESS  
Ashburton St

E 33183

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33183

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balt City Hospital 16-26* ST. *16-26* WARD)2. FULL NAME *Clorence C Johnson*(a) RESIDENCE No. *1115* *Horley* ave ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)Length of residence in city or town where death occurred *life* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
(If non-resident give city or town and State)REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *Col* Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *18 9 8*AGE Years Months Days *30* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) *md.*  
(State or country)10 NAME OF FATHER *John Johnson*11 BIRTHPLACE OF FATHER (city or town) *md.*  
(State or country)12 MAIDEN NAME OF MOTHER *Mary Butler*13 BIRTHPLACE OF MOTHER (city or town) *md.*  
(State or country)Informant (Address) *Balt City Hospital*

3-1928

19 HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 19 1928*17 I HEREBY CERTIFY, That I attended deceased from *4-18*, 1928, to *4-19*, 1928 that I last saw him alive on *4-19*, 1928 and that death occurred, on the date stated above, at *2:00* m.

The CAUSE OF DEATH\* was as follows:

*Lung Cancer*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *yes* Date of *4-18-28*Was there an autopsy? *no*What test confirmed diagnosis? *operation*(Signed) *W. L. Jones*, M. D.19 (Address) *Balt City Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Union Bridge Rd 4/24/28*  
UNDER-TAKER *Samuel Carter*  
ADDRESS *Home*

E 33184

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33184

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *13-59* WARD)2-FULL NAME *Emily Norwood Jarrett*(a) RESIDENCE NO. *706 Reservoir* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *7* yrs. *—* mos. *29* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 15, 1913*

7 AGE

Years

Months

Days

*5**0**28*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Maryland*10 NAME OF FATHER *James H. Jarrett*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Petersburg Virginia*12 MAIDEN NAME OF MOTHER *Rebecca Michie*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Durham N. C.*

Informant (Address)

*James H. Jarrett 706 Reservoir St.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 22, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 20, 1928*, to *April 22, 1928*, that I last saw her alive on *April 21, 1928*, and that death occurred, on the date stated above, at *4:20 p. m.*

The CAUSE OF DEATH\* was as follows:

*Acute tonsillitis*(duration) yrs. mon *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *Yes* Date of *4-20-28*Was there an autopsy? *No*What test confirmed diagnosis? *Bacteriological*

(Signed)

*Dr. J. K. Levin*, M. D.4-22, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Druid Ridge Cemetery April 24, 1928*

20 UNDERTAKER

ADDRESS

*Chas. G. Black 742 W. North Ave.*

1928

19

HARISON JONES, M. D.

REGISTER

E 33185

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1332 Shields Alley)

## 2-FULL NAME

(a) Residence No. 1332 Shields Alley

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE,

If LESS than 1 day,

yrs.

mos.

ds.

min.

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town, State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (city or town, State or Country)

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town, State or Country)

14-

(Informant)

(Address)

15-

Filed

C. HARRISON JONES, R. D.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 4-22-28

17- I HEREBY CERTIFY, That I attended deceased from April 22, 1928, to April 22, 1928, that I last saw him alive on April 22, 1928, and that death occurred, on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH\* was as follows:

Cyanosis (Congested)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

16

(Address)

M. D.

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

APR 23 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33186

## CERTIFICATE OF DEATH.

E 33186

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

University Hospital - 30 Ward

## 2-FULL NAME

James Gosnell

(a) RESIDENCE NO.

Savage, Md St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 1 - 1900

7 AGE

Years

Months

Days

28

1

22

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

mill worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md

10 NAME OF FATHER

Charles Gosnell

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Florence O'Connell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pa

14

Informant (Address)

Mr. Wm. Gosnell Savage, Md

15 Filed 1928

C. HAMPTON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 23 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured Skull (see)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Subdural hemorrhage

(Signed)

Eugene J. Allen, M. D. (Coroner)

4/23, 1928

Address 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Savage, Md

Apr. 25 1928

20 UNDERTAKER

ADDRESS

Alwood N. Fisher

Laurie, Md.

## HEALTH DEPARTMENT-CITY OF BALTIMORE

E 33187

E 33187

## CERTIFICATE OF DEATH

1-PLACE OF DEATH *Aged Womens Home*City of BALTIMORE: (No. *1404 W Lexington* St. *14-27* Ward)2-FULL NAME *Miss Mary M. Sarbacher*(a) RESIDENCE NO. *1404 W Lexington* St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

*Joseph Sarbacher**2644 Maryland Ave**C. HANFORD JONES, R. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 15, 1927, to April 21, 1928* that I last saw him alive on *April 20, 1928* and that death occurred, on the date stated above, at *7 P.M.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis, Chronic*

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Western Cemetery**April 21 1928*

20 UNDERTAKER

ADDRESS *1532 Hollins**George J. Smith*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33188

## CERTIFICATE OF DEATH.

E 33188

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 Humbert ST., 24-35 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1426 Humbert St.

(Usual place of abode)

Length of residence in city or town where death occurred About 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Branku6 DATE OF BIRTH (month, day, and year) March 14, 18737 AGE Years 55 Months 1 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (none)(b) General nature of industry, business, or establishment in which employed (or employer) Housewife(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Houston - Hungary10 NAME OF FATHER Joseph Branku11 BIRTHPLACE OF FATHER (city or town) (State or country) Houston - Hungary12 MAIDEN NAME OF MOTHER Esther Meyer13 BIRTHPLACE OF MOTHER (city or town) (State or country) Houston - Hungary

14

Informant (Address) Joe Branku

15

1028

C. 19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1928, to April 22, 1928.that I last saw her alive on April 21, 1928.and that death occurred, on the date stated above, at 1220 A m.

The CAUSE OF DEATH\* was as follows:

Chronic Int. Nephritis  
Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. J. Warr4.21.28 (Address) 516 Calver St.

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Loudon Park CemeteryDATE OF BURIAL Apr. 24, 1928UNDERTAKER Margaret J. ByrneADDRESS 1422 Light St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33189

## CERTIFICATE OF DEATH.

31 E 33189

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 warren ave

## 2-FULL NAME

m. Frank Hughes

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 102 warren ave

ST. WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male White Divorced

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Rose

6 DATE OF BIRTH (month, day, and year)

Jan. 14, 1872

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

56 3 7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Retired

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balt. Md.

10 NAME OF FATHER

Edward Hughes

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Catherine Hogan

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ireland

14

Informant  
(Address)Charles Hughes  
102 warren ave

15

FILED

G. HANFORD JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
April 1, 1928, to April 22, 1928.

that I last saw him alive on April 22, 1928

and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis,  
myocarditis, chronic nephritis

(duration) Don't know yrs. mos. ds.

CONTRIBUTORY Cardiac Dilatation with  
(Secondary) Decompensation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

Address: 107 East west st

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Cathedral Cemetery Apr. 24 1928

UNDERTAKER

ADDRESS

Margaret J. Flynn 1400 High st



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33190

## CERTIFICATE OF DEATH.

E 33190

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 Mc Kewin Ave 9-47 WARD)2-FULL NAME Mattie F. Gregory(a) RESIDENCE NO. 622 Mc Kewin Ave

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 3 mos. 2 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married6 If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. GregoryDATE OF BIRTH (month, day, and year) 1-20-1869

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5932

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md10 NAME OF FATHER Henry S. Taylor

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md12 MAIDEN NAME OF MOTHER Phoebe T. Meyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto MdInformant Wm. J. Gregory(Address) 622 Mc Kewin AveFiled 3-19-28

19

G. HANCOCK JONES, R. L. E.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22-28

17

I HEREBY CERTIFY, That I attended deceased from 3-24, 1928, to 4-22, 1928 that I last saw him alive on 4-22, 1928 and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction(duration) yrs. mos. 2 ds.CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical signs(Signed) Daniel Miller

M. D.

(Address) 1500 N Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL Greenmount

DATE OF BURIAL

19

20 UNDERTAKER Geo H Little

ADDRESS

E 33191

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33191

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5006 Wilson Ave.

ST. 27-56 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilian C. Miles.

(a) RESIDENCE No. 5006 Wilson Ave.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female, White.

Single.

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Single.

DATE OF BIRTH (month, day, and year) Sept. 21, 1907.

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20.

7.

1.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sales. Lady.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Stewart &amp; Co.

BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

John E. Miles.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Anna La Bonte.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto. Md.

Informant

Anna Miles. (Mother).

(Address)

545 W. Hamburg St.

3-1928

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 5, 1928, to Apr 22, 1928, that I last saw her alive on Apr 22, 1928, and that death occurred, on the date stated above, at 120 P. M.

The CAUSE OF DEATH\* was as follows:

Encephalitis (not Epidemic).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. S. Hubert

M. D.

4/23/28

(Address)

2220 Garrison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Druid Ridge Cem April 25, 1928  
A. Howard Evans 358 E. Ford Ave

E 33192

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

303 Whitbridge ST., 45-50 WARD)

## 2-FULL NAME

Margaret Rebecca Tucker

(a) RESIDENCE NO.

303 Whitbridge

ST.,

WARD

Churchhill-Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

0 yrs.

1 mos.

0 ds.

How long in U. S., if of foreign birth?

73 yrs.

2 mos.

9 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James Tucker

6 DATE OF BIRTH (month, day, and year)

Feb 13/1855

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs or min.

73

2

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Chesler town Maryland

10 NAME OF FATHER

Joshua Corden

11 BIRTHPLACE OF FATHER (city or town)

Kent Co

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sarah Hendricks

13 BIRTHPLACE OF MOTHER (city or town)

Kent Co

(State or country)

Md.

14 Informant

Mrs. Sallie Tucker (daughter)

(Address)

303 Whitbridge

15

Filed

19

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 22 1928

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1928, to April 22, 1928, that I last saw him alive on April 23, 1928, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

myocardia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Cerebral meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

John A. Gray

M. D.

, 19

(Address)

612 W. 4th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MORAL

Churchhill-Crematorium

April 24/28

20 UNDERTAKER

Stewart &amp; Son

Baltimore

E 33193

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (N

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

6a If married, widowed, or divorced

HUSBAND or

(or) WIFE of

Frederick Burger

6 DATE OF BIRTH (month, day, and year)

3-25-1851

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

77

0

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

10 NAME OF FATHER

Frank Wehr

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Do Not Know

12 MAIDEN NAME OF MOTHER

Mary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Do Not Know

14

Informant

(Address)

Helen Burger  
1811 W North Ave

15

Filed

C. HANCOCK JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/20 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Intermittent Insanity  
Due to Accident

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed)

M. D.

4/23, 1928 (Address) 3632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Church 4-24-1928

20 UNDERTAKER

ADDRESS

M. Fahay &amp; Sons 1827 W North Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33194

## CERTIFICATE OF DEATH.

31 E 33194

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals (4-25) ST. 4-25 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Snowden(a) RESIDENCE NO. 645 Redwood st.

(Usual place of abode)

ST. 4-25 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) 18857 AGE Years 43 Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer UnknownBIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Alfred Snowden11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Eliza ?13 BIRTHPLACE OF MOTHER (city or town) (State or country) UnknownInformant Hospital Records (Address)

Filed

24 1928

JONES, H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 192817 I HEREBY CERTIFY, That I attended deceased from March 28, 1928 to April 21, 1928that I last saw him alive on April 21, 1928and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Clinical & Autopsy (Signed) J. P. M. D.4-23-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Undertaker4/24/28Undertaker9/6/28

213254  
E 33195

## HEALTH DEPARTMENT—CITY OF BALTIMORE

3100 E 33195

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHN HOPKINS HOSPITAL

ST. 6-11

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Genge Chester (Everett Butler)

## (a) RESIDENCE NO.

206 East St

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Black

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 12-12-26

## AGE

Years 1

Months 10

Days 9

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Ind -

## 10 NAME OF FATHER

Everett -

## 11 BIRTHPLACE OF FATHER (city or town)

Ind -

(State or country)

## 12 MAIDEN NAME OF MOTHER

Sadie Brown

## 13 BIRTHPLACE OF MOTHER (city or town)

Ind -

(State or country)

Informant (Address)

Filed

24 1928C. HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 18, 1928, to Apr. 21, 1928.

that I last saw him live on April 21, 1928.

and that death occurred, on the date stated above, at 5-06 a.m.

The CAUSE OF DEATH\* was as follows:

Miliary Tuberculosis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY Tuberculosis meningitis (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death? No Date of

Was there an autopsy? yes

T.b. bacilli in Spinal Fluid

What test confirmed diagnosis?

(Signed) J. B. Bennett, M. D.

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS 1217

Byron Wright

McElderry

912475  
E 33196

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113 E 33196

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

JOHNS HOPKINS HOSPITAL

## 2-FULL NAME

Gloria Robinson

ST.

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1121 Argyle Ave

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD

(If non-resident give city or town and State)

How long in U. S. If of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 7, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7/12/28 15

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Md -

10 NAME OF FATHER

Lazid Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

La -

12 MAIDEN NAME OF MOTHER

Bertha Jabb

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

La -

Informant (Address)

Records -

Filed

19

Registrar

17-24

ST.

WARD

ST.

WARD

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1928, to April 22, 1928, that I last saw her alive on April 22, 1928, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia

Diarrhea - Acute primary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

19 (Address) Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

Mr. Robinson

UNDERTAKER

DATE OF BURIAL

4/24/28

ADDRESS

## E 33197 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 N. Fulton Ave. ST. 16-22

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Anna Bullens

(a) RESIDENCE NO. 1012 N. Fulton Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, 5 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

24 1928

C. HAZARD JONES, JR.

Registrar

WARD

WARD

(If non-resident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23<sup>rd</sup> 1928

17 I HEREBY CERTIFY, That I attended deceased from Apr 23, 1928, to Apr 23, 1928, that I last saw her alive on Apr 23, 1928, and that death occurred, on the date stated above, at 5:50 a.m.

The CAUSE OF DEATH\* was as follows:

Cardiac Failure

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Apr. 1928

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33198

## CERTIFICATE OF DEATH.

129E 33198

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9. Woodland ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

William R. Shambliff

## (a) RESIDENCE NO.

9. Woodland

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, Divorced; (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Rosa. W. Shambliff

## 6 DATE OF BIRTH (month, day, and year)

Dec. 11, 1867

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

7

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Litho

## (b) General nature of industry, business, or establishment in which employed (or employer)

Design

## (c) Name of employer

Bald. E. Co

## 9 BIRTHPLACE (city or town) (State or country)

Kansas City

## 10 NAME OF FATHER

John Shambliff

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Kansas City

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Kansas City

## 14

Informant (Address)

Mrs. Rosa. W. Shambliff 9. Woodland St. Baltimore

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

4-18-28

## 17

HEREBY CERTIFY, That I attended deceased from

July 1, 1928, to April 20, 1928, the I last saw him alive on April 18, 1928, and that death occurred, on the date stated above, at 4:00 p.m.

The CAUSE OF DEATH was as follows:

Cerebral Refractoriness  
Exquisite Hyperkalemia

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 4 mos. 1 ds. Acute Cardiac Failure

## 18 Where was disease contracted if not at place of death?

unknown

## Did an operation precede death?

No

## Was there an autopsy?

No

## What test confirmed diagnosis?

Finding

(Signed)

47328 7th Ave. S. D. 800 N. W. 12th

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Landon Park Cemetery

April 23, 1928

## 20 UNDERTAKER

J. R. Rust 7735 Harford

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33199

## CERTIFICATE OF DEATH.

E 33199

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1318 Entaw Place 11-24 Ward)2-FULL NAME David E. Gilmer(a) RESIDENCE NO. 1318 Entaw Place Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Floride Gilmer

6 DATE OF BIRTH (month, day, and year)

Nov 11 - 1888

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.39511

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Real Estate Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Toronto Canada  
Howard Lake Minn

10 NAME OF FATHER

Allen Gilmer

11 BIRTHPLACE OF FATHER (city or town)

Ontario Canada

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Canada

(State or country)

14

Informant  
(Address)Floride Gilmer1318 Entaw Place

15 Filed

PR 24 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Old Media(duration) 9 yrs. ....mos. ....ds.CONTRIBUTORY  
(Secondary)(duration) 7 yrs. ....mos. ....ds.

(Signed)

J. E. Smith M. D.

(Address)

Nathan & Lewis St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

at place of death yrs. ....mos. ....ds. State yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Woodlawn CemApril 24 1928

20 UNDERTAKER

ADDRESS

James B. Hayes1324 Entaw Pl

212565  
E 33200

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

145E 33200

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10-14 ST., 16-14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Bessie Taylor

## (a) RESIDENCE NO.

739 Sterling

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1/2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Black

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

?

## 6 DATE OF BIRTH (month, day, and year)

1901

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Housewife

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## BIRTHPLACE (city or town) (State or country)

Ind -

## 10 NAME OF FATHER

Frank Samson

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind -

## 12 MAIDEN NAME OF MOTHER

Edith Taylor

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind -

## Informant (Address)

Records -

## Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 22 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 28, 1928, to April 22, 1928.

that I last saw her alive on April 22, 1928.

and that death occurred, on the date stated above, at 5:20 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(Post Operative)

(duration) yrs. mos. 25 ds.

## CONTRIBUTORY (Secondary)

Hypertension (Nephritis)

(duration) yrs. mos. 1 ds.

## 18 Where was disease contracted if not at place of death?

Home

## Did an operation precede death?

Yes Date of 3-28-28

## Was there an autopsy?

Yes

## What test confirmed diagnosis?

Autopsy

(Signed) J. H. Williams, M. D.

1-23-1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Pleasant Rest.

Apr 24, 1928

## UNDERTAKER

Mrs. R. G. Elliott

## ADDRESS

1725 Ashland

# Mlinar

## E 33201 HEALTH DEPARTMENT—CITY OF BALTIMORE

### CERTIFICATE OF DEATH.

E 33201

#### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital* *76-72* WARD)

#### 2-FULL NAME

*Mrs Teresa Mlinar*(a) RESIDENCE NO. *1446 Chambers St.* ST. *St. Louis, Mo.* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *6* mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO. *76-72*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

#### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Michael Mlinar*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*59*

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Hungary*

10 NAME OF FATHER

*Michael Mlinar*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Hungary*12 MAIDEN NAME OF MOTHER *not given*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Hungary*

Informant (Address)

*Emil Mlinar (Long Island City, N.Y.)*

Filed

*24 1928*

Registrar

#### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-23* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *10-14*, 19 *27*, to *4-23*, 19 *28*.that I last saw him alive on *4-23*, 19 *28*and that death occurred, on the date stated above, at *4 P. M.*The CAUSE OF DEATH\* was as follows:  
*Carcinoma of breast.*

(duration) yrs. *8 1/2* mos. ds.

CONCOMITANT (Secondary) *Metastatic Carcinomatosis*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *Oct 17, 1927*Was there an autopsy? *No*What test confirmed diagnosis? *Microscopic Exam.**Augustine J. Van Schuerbeek**St. Agnes Hospital*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

*St. Louis Mo Apr. 24 1928*

20 UNDERTAKER

ADDRESS

*John C. Mitchell Sons 1900 E. Main St. St. Louis Mo*



E 33202

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33202

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital*)St. *4-25* Ward

REGISTERED NO.

2-FULL NAME *Emma Reed*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *105 E Mulberry*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female Colored**Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Unknown*

6 DATE OF BIRTH (month, day, and year)

*Unknown 1865*

7 AGE

Years

Months

Days

*63(?)*

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*MD*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*

14

Informant (Address)

*Lemire Phillips 105 E. Mulberry St.*

15

Filed

24 1928

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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/10/28*

17

I HEREBY CERTIFY, That I attended deceased from

*4/16/28*, 19\_\_\_\_, to *4/20/28*, 19\_\_\_\_,that I last saw *her* alive on *4/20/28*, 19\_\_\_\_,and that death occurred, on the date stated above, at *10:10 a.m.*

The CAUSE OF DEATH\* was as follows:

*2nd Degree Burns of Back and Abdomen*

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

CONTRIBUTORY *Nephritis & Uremia*

(Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? \_\_\_\_ Date of \_\_\_\_

Was there an autopsy? \_\_\_\_

What test confirmed diagnosis? *Chemical*(Signed) *J. S. Winick*, M. D.\_\_\_\_ 19\_\_\_\_ (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*New Catholic Church Apr. 24, 1928*

20 UNDERTAKER

ADDRESS

*Mrs. R. G. Elliott Washburn*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33203

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (NOT

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town,  
State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town,  
State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town,  
State or country)Informant  
(Address)

Filed

19

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
June 1927, to April 21, 1928.  
that I last saw her alive on April 21, 1928,  
and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of breast—runge  
about 2 years past—death  
resulted from exhaustion or  
Carcinoma duration) yrs. 2 mos. ds.CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4-23-28

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33204

## CERTIFICATE OF DEATH

46 ✓ E 33204

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 53 South 11th St. 76-37 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 53 South 11th St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Dodd

6 DATE OF BIRTH (month, day, and year)

Apr 6, 1864

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

64 0 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

none At Home housewife self

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

William L Bell Baltimore Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Louise (Whitman) 4/23/28 (Address) 1014 S. Ellwood Ave.

14

Informant (Address)

William Dodd 53 South 11th St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

17

I HEREBY CERTIFY, That I attended deceased from

Jan 16, 1928, to April 22, 1928,

that I last saw her alive on April 21, 1928,

and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH\* was as follows:

Pelvic carcinoma (cystic)

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY

(Secondary)

exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? diagnosis made at Johns Hopkins

(Signed)

4/23/28 (Address)

1014 S. Ellwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Oak Lawn

Apr 25 1928

UNDERTAKER

ADDRESS

J. M. Cook

302 E. North Ave.

15 File

R 24 1928

H. J. JONES, M. D. Registrar





E 33206

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital 18-16*)

## 2-FULL NAME

(a) RESIDENCE NO. *215*(Usual place of abode)  
Length of residence in city or town where death occurred *16* yrs.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*male*

## 4 Color or Race

*colored*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*year 1878*

## 7 AGE

*50*

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Laborer*9 BIRTHPLACE (city or town)  
(State or country)*va*

## 10 NAME OF FATHER

*Robert Samuels*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*va*

## 12 MAIDEN NAME OF MOTHER

*Martha Jones*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*va*

## 14

Informant  
(Address)*Robert Samuels (brother)  
1113 Sarah Amst*

## 15 Filed

*1928**39**H. J. JONES, R. E. J.*

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Apr 21 1928*17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.  
The CAUSE OF DEATH was as follows:*Hypertension*

## CONTRIBUTORY (Secondary)

*Cardiac Anemia  
Apr 18 1928  
64 (duration) 14 3/4 yrs.  
19 (address) 14316 Bway  
(Coroner) M. D.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*mt. Auburn cemetery*

## 20 UNDERTAKER

*Mrs. Kate R. Williams*

## Date of Burial

*4/24 1928*

## ADDRESS

*322 N. Schreder St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33207.

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Child

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

6-1-1919

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min..

8

10

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Child

Child

None

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

10 NAME OF FATHER

Geo McGill

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Ada Bryan

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore

14

Informant  
(Address)

Hyacinth

15 Filed

APR 24 1928

19

R. M. L. Registrar

REGISTERED NO.

E 33207.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-23-28

17

I HEREBY CERTIFY, That I attended deceased from

4-20-28

to

4-23-28

that I last saw him alive on

4-23-28

and that death occurred, on the date stated above, at

8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Acute appendicitis

CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

ds.

Peritonitis &amp; Pharyngeal edema

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

Yes

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

4-19-28

(Address)

M. D.

State the Cause Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park  
John H. Denny

Date of Burial

Apr 25 1928

20 UNDERTAKER

ADDRESS

715 Light

E 33208

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

88 E 33208

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *16-34* WARD)

## 2-FULL NAME

*Virginia Kraft*

## (a) RESIDENCE NO.

(Usual place of abode)

*633 N. Highland*

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

*John*

## 7 DATE OF BIRTH (month, day, and year)

*March 4 - 1895*

## AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*33**1**18*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

## 10 NAME OF FATHER

*Harry P. Kraft, Sr.*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore, Md.*

## 12 MAIDEN NAME OF MOTHER

*Josephine Gearish*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore, Md.*

Informant (Address)

*Josephine Kraft  
633 N. Highland Ave*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/22/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*4/6/28*

, 19

*4/22/28*

, 19

that I last saw him alive on *4/22/28*, 19and that death occurred, on the date stated above, at *4:50 P.* m.

The CAUSE OF DEATH\* was as follows:

*malignant endocarditis*

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

*cerebral embolus*

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*H. Lawrence Fahmy, M.D.*

, 19

(Address)

*St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Oaklawn Cemetery*

## UNDERTAKER

*George W. Zirkler*

## DATE OF BURIAL

*Apr 26 1928*

## ADDRESS

*1737 E. Egan St*Filed *24 1928**H. J. JONES, R.*

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33209

## CERTIFICATE OF DEATH

90 E 33209

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 408 N Monroe St., 19-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James S. McFarland

(a) RESIDENCE NO. 408 N Monroe St., St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie (Nee Grumbine)

6 DATE OF BIRTH (month, day, and year)

Jan 31, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
56	2	3	19 21	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deputy Sheriff

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER James S. McFarland

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mrs. Mollie McFarland  
(Address) 408 N Monroe St.

15 Filed 19 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 19 28

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 28 to Apr 20 28 that I last saw him alive on Apr 20 28

and that death occurred, on the date stated above, at 7:10 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Distention

## CONTRIBUTORY

(Secondary)

Chronic Myocarditis (duration) 2 yrs. mos. da.

18 Where was disease contracted

If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physiological

(Signed) James B. [Signature] 4/23/28 (Address) 1729 1/2 [Address]

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Druid Ridge Cemetery Apr. 26/28

20 UNDERTAKER

ADDRESS

Harry N. Witzke 15314 Lombard



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33210

## CERTIFICATE OF DEATH

99-001  
E 33210

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1332 N. Guilford St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 1332 N. Guilford St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 mos. 1 ds. How long in U. S. if of foreign birth? 2 yrs. 1 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male colored single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 15<sup>th</sup> 1912

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

15

8

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

school boy

9 BIRTHPLACE (city or town)

(State or country)

City

10 NAME OF FATHER

Ford Young

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

St. Mary's Co.

12 MAIDEN NAME OF MOTHER

Mary Bender

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

St. Mary's Co.

14

Informant  
(Address)Mary Bender  
1332 N. Guilford St.

15 Filed

PR 24 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

April 22 - 1928

17

I HEREBY CERTIFY, That I attended deceased from

March 28, 1928, to April 22, 1928,

that I last saw him alive on April 22, 1928,

and that death occurred, on the date stated above, at 9:20 p. m.

The CAUSE OF DEATH\* was as follows:

Bronchitis Acute

(duration)

10 yrs. 10 mos. 1 da.

CONTRIBUTORY

(Secondary)

Nasal Hemorrhage

(duration)

1 yrs. 1 mos. 1 da.

18 Where was disease contracted

if not at place of death? ☒Did an operation precede death? ☒ Date of ☒Was there an autopsy? ☒

What test confirmed diagnosis? Clinical methods

(Signed)

George C. Shannon, M. D.

4/22-1928 (Address)

700 Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Peter's - York

19

20 UNDERTAKER

ADDRESS

Shannon &amp; Wright 344 N. York

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33211

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Millington Lane ST. 20th WARD)2-FULL NAME Geraldine P. Sheppard(a) RESIDENCE NO. 417 Millington Lane ST. 20th WARD  
(Usual place of abode)Length of residence in city or town where death occurred yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29/287 AGE Years Months Days 23 If LESS than 1 day, hrs. 24 or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md10 NAME OF FATHER William H. Sheppard11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md12 MAIDEN NAME OF MOTHER Louise T. Root13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, MdInformant (Address) 417 Millington Lane

R 24 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1928, to April 22, 1928,that I last saw her alive on April 22, 1928,and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH\* was as follows:

Hydrocoyst 3 weeks +

(duration) yrs. mos. ds.

CONTRIBUTORY Convulsions  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical(Signed) E. H. Henshaw, M.D.4/23, 1928 (Address) 24 4 Fullan St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Lincoln Park Cemetery DATE OF BURIAL April 24, 192820 UNDERTAKER W. H. HenshawADDRESS 1850 W. Baltimore St

E 33212

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

109-002  
E 33212

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

Sydenham Hospital 8-16  
ST. WARD)

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## 2-FULL NAME

Albert Helms

## (a) RESIDENCE NO.

2305 E. Lafayette Ave  
(Usual place of abode)

Length of residence in city or town where death occurred

Lifers mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed,

Divorced (write the word)  
Single5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Feb. 9, 1926

## 7 AGE

Years

Months

Days 14

If LESS than  
1 day, hrs.  
or min.

2

2

15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

child

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

## 10 NAME OF FATHER

A. A. Helms

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Penna.

## 12 MAIDEN NAME OF MOTHER

Alma Bristow

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Va

Informant  
(Address)

Mrs. A. A. Helms

2305 E. Lafayette Ave

Filed

24 1928

H. J. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 23 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 6, 1928, to April 23, 1928,

that I last saw him alive on April 13, 1928,

and that death occurred, on the date stated above, at 8:20 P. M.

The CAUSE OF DEATH\* was as follows:

Streptococcic Sore Throat

(duration)

yrs.

mos.

23

ds.

CONTRIBUTORY  
(Secondary)

Bronchopneumonia

(duration)

yrs.

mos.

10

ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical

(Signed)

Myron G. Jule

M. D.

1/24, 1928 (Address) Sydenham Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Baltimore County

## DATE OF BURIAL

4/25/28

## 20 UNDERTAKER

William Cook

## ADDRESS

502 E. Mt. ...

E 33213

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33213  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, IN

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

7 yrs. mos. ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

March 20, 19 28, to April 24, 19 28, that I last saw her live on April 24, 19 28, and that death occurred, on the date stated above, at 12 20 p. m.

The CAUSE OF DEATH\* was as follows:

Hypertensive Cardio Vascular disease  
Auricular Fibrillation  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis T. Levy, M. D.

24 28 (Address) W. Balto Gen. Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33214

## CERTIFICATE OF DEATH.

E 33214

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1229 N. Lafayette ST. 18-26 WARD)

2-FULL NAME George Herbert Matthews

(a) RESIDENCE No. 1229 N. Lafayette ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eunice Matthews

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE Years 29 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Major Matthews

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Jackson

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Eunice Matthews (Address) 1229 N. Lafayette St.

15 Filed 24-1928 19 12:11 PM JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20, 1928

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1927, to Apr 19, 1928, that last saw him alive on Apr 19, 1928

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis Indefinite (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. (Signed) Garland M. D.

(Address) 1534 - 1st St. W. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL CREMATION OR RE-MOVAL

## DATE OF BURIAL

Mt Auburn and Apr 24, 1928

## 20 UNDERTAKER

## ADDRESS

Wm. R. A. Elliott 1725 Oakland

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33215

## CERTIFICATE OF DEATH.

78 E 33215

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 135 Hollins St., 18-29 Ward)2-FULL NAME Salvatore Scalco(a) RESIDENCE NO. 1135 Hollins St., \_\_\_\_\_ Ward \_\_\_\_\_(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Sept 9<sup>th</sup> 19127 AGE Years 15 Months 7 Days 14 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER Sam Scalco11 BIRTHPLACE OF FATHER (city or town) Italy  
(State or country)12 MAIDEN NAME OF MOTHER Constata Remando13 BIRTHPLACE OF MOTHER (city or town) Italy  
(State or country)

14

Informant Sam Scalco  
(Address) 1135 Hollins St

15 Filed

18

C. H. JONES, M. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Epilepsy, Haemorrhage, Asphyxia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

Apr 23 1928 (Signed) G. C. Stader (Coroner) M. D.  
(Address) 143 N. Bay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death!.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer4/25 1928

20 UNDERTAKER

ADDRESS

Robert Brooks & SonCalhoun Hollins St

E 33216

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. \_\_\_\_\_ St., \_\_\_\_\_ Ward)

## 2-FULL NAME

(a) RESIDENCE NO. \_\_\_\_\_ St., \_\_\_\_\_ Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaiah Lee

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years 56 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) M.D. (State or country)

10 NAME OF FATHER James Godbrison

11 BIRTHPLACE OF FATHER (city or town) M.D. (State or country)

12 MAIDEN NAME OF MOTHER Eliza Stanley

13 BIRTHPLACE OF MOTHER (city or town) M.D. (State or country)

14 Informant Isaiah Lee (Address) 1628 E. Lombard St

15 Filed 1928 Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia R Side

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Signed: G. C. Shady (duration) yrs. mos. ds.

28 (Address) 43 W. Bay

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Asbury cemetery

April 25 1928

20 UNDERTAKER

Edward Bryan

ADDRESS 1631 Orleans St

E 33217

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

24 1928 HAMILTON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Nov 17 to 19 18 to Dec 13 19 28 that I last saw her alive on Nov 20, 19 28 and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

1931 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS



E 33218

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33218

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1212 E Lafayette Ave* ST. *49* WARD)2-FULL NAME *John A. Rhein*(a) RESIDENCE NO. *1212 E Lafayette*

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. mos.

ST., WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Caroline Rhein*DATE OF BIRTH (month, day, and year) *Aug 3 - 1856*AGE Years *71* Months *8* Days *19* If LESS than 1 day, his or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Labor.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Wilmington Del*10 NAME OF FATHER *John A. Rhein*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Catherine Heine*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Prague Bohemia*Informant (Address) *Mrs. Harry H. Campbell*Filed *1936*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 22 1928.*17 I HEREBY CERTIFY, That I attended deceased from *3/15/28*, 19 *28*, to *4/22/28*, 19 *28*, that I last saw him live on *4/22/28*, 19 *28*, and that death occurred, on the date stated above, at *3:40 p.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Prostate (metastasis).*(duration) yrs. *1* mos. *7* ds.CONTRIBUTORY (Secondary) *Pulmonary edema.*(duration) yrs. mos. *1* da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *Jan 1926.*Was there an autopsy? *no*What test confirmed diagnosis? *Microscopic ex.*(Signed) *J. A. Borden*

M. D.

4/22/28 (Address) *1517 E North Ave.*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Greenwood Cemetery*DATE OF BURIAL *Apr 25 1928*UNDERTAKER *A. S. Marshall*ADDRESS *539 Fall Rock*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33219

## CERTIFICATE OF DEATH.

31  
E 33219

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 21-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius Hunt(a) RESIDENCE No 1447 Columbus ST., Portsmouth Va.  
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of or WIFE of Victoria HuntDATE OF BIRTH (month, day, and year) ?  
AGE Years Months Days If LESS than 1 day, hrs. or min. 37

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER George Hunt11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Eleanor ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant (Address) RecordsFiled 24 1928 Registrar W. H. Jones

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 / 23 / 1928

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1928 to April 23, 1928 that I last saw him live on April 23, 1928 and that death occurred, on the date stated above, at 2:00 A. in.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? General & Lab.(Signed) C. Holmes Boyd M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Portsmouth Va.  
UNDERTAKER4/24 1928

ADDRESS

Isaac L. Brown 189 Montz St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33220

33220

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital 76-37* St. *16* Ward *37*)2-FULL NAME *Jacob M. Simpson*(a) RESIDENCE NO. *City Hospital* St. *16* Ward *37*

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. *188-003*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *the late Richard F. Simpson*6 DATE OF BIRTH (month, day, and year) *Dec. 12 - 1860*7 AGE Years *67* Months *4* Days *9* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Matron at*(b) General nature of industry, business, or establishment in which employed (or employer) *Municipal Hospital*

(c) Name of employer

9 BIRTHPLACE (city or town) *Charles Co. Md.* (State or country)10 NAME OF FATHER *Wm. M. Mahon*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Katie Lynch*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*14 Informant *Thos. M. Charles son in law* (Address) *1111 Hill Fullerton Baltimore*15 REGISTRAR *J. P. Jones* Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 21 1928*

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: *Auto. Acc.**Multiple Fractures* (duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *Stroke* (duration) yrs. mos. ds.(Signed) *G. C. Bladus* M. D. (Address) *1436 Bway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death!

Former or usual residence.....

PLACE OF BURIAL, CREMATION OR REMOVAL *St. Patrick's Cem. Md.* Date of Burial *April 26 1928*20 UNDERTAKER *Kelly & Ziehl Sons* ADDRESS *4038 Wolfe St.*

E 33221

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33221

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3 St. Helens Ave. St. 27-44 Ward)2-FULL NAME Mary E. Rolfe(a) RESIDENCE NO. 3 St. Helens Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of the late Anthony Rolfe

6 DATE OF BIRTH (month, day, and year)

Nov. 4<sup>th</sup> 1851

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

76

5

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.

Retired

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto. Co. Md.

(State or country)

10 NAME OF FATHER

August Bocklage

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Ely. Brownlage

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant  
(Address)Anna E. Brown  
3 St. Helens Ave.

15

Filed

16

G. HANSON JONES, M.D.  
1928

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

April 22<sup>nd</sup>

17

I HEREBY CERTIFY, That I attended deceased from

Jan 4, 1928, to April 21, 1928,

that I last saw him alive on April 21, 1928,

and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Degeneration

(duration) 1 yrs. - mos. - ds.

CONTRIBUTORY

(Secondary)

(duration) 2 yrs. - mos. - ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Stanley M. M.D.

19

(Address)

1609 Linden Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cem. April 25 1928

20 UNDERTAKER

ADDRESS

Lilly &amp; Zeller Inc. 4805 W. 1st St.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33223

## CERTIFICATE OF DEATH.

188-003 E 33223  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary 1-3 Ward)

## 2-FULL NAME

M. Joseph Novak

(a) RESIDENCE NO. 509 S. Bradford

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 16/1921

7 AGE

Years

6

Months

5

Days

7

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....none(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

Balto., Md.

10 NAME OF FATHER

Adam Novak

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Dora Milecki

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Maryland

14

Informant  
(Address)

Father

15 Filed.....

19

HARRISON JONES, R. J.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 23/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-inquiry.....and that said deceased came to his death  
(Inquest, au-

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage-No frac. Skull

Acc. Struck by autotruck at

Eastern and Montford Avenues.

CONTRIBUTORY  
(Secondary)(duration).....yrs.....mos.....ds.  
(Signed) J. H. Miller M. D.  
(Coroner)

4/24/28 (Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

St. Stanislaus

Date of Burial

Apr 26, 1928

ADDRESS

20 UNDERTAKER

M. J. Sachowski, 708 E. Union

E 33224

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33224

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* *12-19* St. *49* Ward)2-FULL NAME *Louis E. Bergerson*(a) RESIDENCE NO *2016 St Paul*

(Usual place of abode)

St. *49* Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred / yrs. - mos. - ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

*Male* *White**Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Beatrice Baldwin*

6 DATE OF BIRTH (month, day, and year)

*October 6, 1887*

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min..

*40* *6* *15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Insurance Salesman**males. mutual life*

9 BIRTHPLACE (city or town)

(State or country)

*Chicago**Ill.*

10 NAME OF FATHER

*Louis B. Bergerson*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Norway*

12 MAIDEN NAME OF MOTHER

*Mary Cox*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Mo.*

14

Informant (Address)

*Mrs. Beatrice B. Bergerson*  
*2016 St. Paul St.*

15 Filed

*C. H. HARRISON JONES, M. D.*  
*R. R. H.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/24/28*

17

I HEREBY CERTIFY, That I attended deceased from *4/14/28*, 19\_\_\_\_, to *4/24/28*, 19\_\_\_\_,that I last saw he *5* alive on *4/24/28*, 19\_\_\_\_, and that death occurred, on the date stated above, at *5:25* a.m.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis & carcinoma of the (left) urinary bladder*  
(duration) *5* yrs. \_\_\_\_ mos. \_\_\_\_ ds.

CONTRIBUTORY

(Secondary)

*Hemorrhage into urinary bladder*  
(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted

If not at place of death? *✓*Did an operation precede death? *yes* Date of *3/3/28*Was there an autopsy? *yes*What test confirmed diagnosis? *Chronic & autopsy*

(Signed)

19

(Address)

*John W. Winstead, M. D.*  
*Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Woodlawn Cemetery*  
*New York, N. Y.**4/26 1928*

20 UNDERTAKER

ADDRESS

*W. W. Winstead & Son - 805 N. Talbot St.*  
*Via Penn. R.R. - Escort Mrs. Beatrice B. Bergerson St.*

E 33225

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33225

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 N. Monroe ST. 16-22 WARD)2. FULL NAME Adelaide E. Townsend

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 709 N. Monroe ST. 16-22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married6a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert E. TownsendDATE OF BIRTH (month, day, and year) Nov 2 1879AGE Years Months 5 Days 20 If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.10 NAME OF FATHER Andrew E. Jones11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.12 MAIDEN NAME OF MOTHER Emeline H. Jones13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.Informant Mrs. Wm. Jones (Address) 1000 N. 1st St. Baltimore

1928 G. H. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 192817 I, HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 22, 1928, that I last saw him alive on Apr 22, 1928, and that death occurred, on the date stated above, at 5:00 m.

The CAUSE OF DEATH\* was as follows:

Septic Throat.  
Septic Pneumonia.  
Encephalitis Lethargica.  
Endocarditis (duration) yrs. mos. 32 ds.CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. 1 ds.18 Where was disease contracted if not at place of death? At HomeDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical  
(Signed) Chas. W. Jones, M. D., 19 (Address) 806 N. Fulton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Olivet Cem.  
20 UNDERTAKER ChenowethApril 25 1928  
ADDRESS 3415 Chestnut



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33226

## CERTIFICATE OF DEATH

132 E 33226

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Monroe Guard Aspt 15-62* St. *15-62* Ward)2-FULL NAME *Mr. Florence Fuchs*(a) RESIDENCE NO. *3507 Edgewood Rd.* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 Color or Race

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced—

(or) WIFE of *Mr. Wm. Fuchs*

6 DATE OF BIRTH (month, day, and year)

*March 4 - 1880*

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min..*48**1**19*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore*10 NAME OF FATHER *Charles Fuchs*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Ida*12 MAIDEN NAME OF MOTHER *Elizabeth Fuchs*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ida*

14

Informant  
(Address)*Hospital Records*

15 Filed

4 1928

C. HARRISON JONES, Registrar

Date

*1928*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*4-23-28*

17

I HEREBY CERTIFY, That I attended deceased from

*4-18-28*, 19, to *4-23-28*, 19that I last saw him alive on *4-23-28*, 19and that death occurred, on the date stated above, at *1142 P.* m.

The CAUSE OF DEATH\* was as follows:

*Myocarditis*

CONTRIBUTORY

(Secondary)

(duration)

*1 1/2 yrs.*

mos.

ds.

(duration)

yrs.

mos.

*3*

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *C. E. Zimmerman*

M. D.

, 19

(Address) *1142 P.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

REMOVAL

Date of Burial

*London Park*

19

20 UNDERTAKER

ADDRESS

*Geo W Little*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33227

## CERTIFICATE OF DEATH.

E 33227

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Charles & 29th St. 12-50 Ward)2-FULL NAME Clarence V. Milholland(a) RESIDENCE NO. Charles Apartments St. 12-50 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 9 mos. 0 ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mae Kinnamon6 DATE OF BIRTH (month, day, and year) July 22, 18847 AGE Years 43 Months 9 Days 0 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. Railroad9 BIRTHPLACE (city or town) Baltimore(State or country) Maryland10 NAME OF FATHER Arthur V. Milholland11 BIRTHPLACE OF FATHER (city or town) Balto.  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Margaret A. Riley13 BIRTHPLACE OF MOTHER (city or town) Balto.  
(State or country) Maryland14 Informant Francis V. Milholland  
(Address) 219 E. University Parkway15 Filed C. HANFORD JONES, R. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fractured Skull  
Due to Accident  
(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) [Signature] M. D. (Coroner)(Address) 3632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery

Date of Burial

4/25 1928

20 UNDERTAKER

ADDRESS

Henry H. Deane's Son 805 N. Calvert

E 33228

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33228

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Agnes Hospital

CITY OF BALTIMORE: (No.

ST. 10-69 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Otto Schroen

(a) RESIDENCE NO.

2552 Boyd St

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs Catherine Schroen

6 DATE OF BIRTH (month, day, and year)

Oct. 11-1880

7 AGE

Years

Months

Days

49

6

10

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

meat seller in slatter house

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

George Schroen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabath Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

Informant

(Address)

Mrs Catherine Schroen 2552 Boyd St

5

1928

C. H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-21-1928

17

I HEREBY CERTIFY, That I attended deceased from 4-11, 1928, to 4-21, 1928,

that I last saw him alive on 4-21, 1928,

and that death occurred, on the date stated above, at 6 05 PM

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

La 2552 Boyd St

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

C. S. P. H. Y.

(Signed)

Fred T. Kyper

M. D.

, 19

(Address) 3321 Frederick Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

George L. Schwan 2101 Clark Ave.

E 33229

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33229

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Providence Hospital* St. *17* Ward *20*)2-FULL NAME *Robert Edward Smith*(a) RESIDENCE NO. *642 W. Bane*

(Usual place of abode)

Length of residence in city or town where death occurred *9* yrs. *0* mos. *0* ds.St. *17* Ward *20*(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 Color or Race

*cal*

5 Single, Married, Widowed, or Divorced, (write the word)

*single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1919*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Va*  
(State or country)10 NAME OF FATHER *Samuel Smith*11 BIRTHPLACE OF FATHER (City or town) *Va.*  
(State or country)12 MAIDEN NAME OF MOTHER *Hattie R. Alb.*13 BIRTHPLACE OF MOTHER (city or town) *Va.*  
(State or country)

14

Informant *Samuel Smith*  
(Address) *642 W. Bane*

15

16 REGISTRATION NO. *19280* *MARTINSON JONES* *DR*

REGISTERED NO.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-22-1948*

17

I HEREBY CERTIFY, That I attended deceased from *4-9*, 19 *48*, to *4-22*, 19 *48*.that I last saw him alive on *4-22*, 19 *48*, and that death occurred, on the date stated above, at *10:50 a.m.*

The CAUSE OF DEATH was as follows:

*Pneumonia*  
*Exacerbation*(duration) yrs. *1* mos. *14* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *642 W. Bane*Did an operation precede death? *yes* Date of *4-11-48*Was there an autopsy? *yes*What test confirmed diagnosis? *operation*(Signed) *W. B. Spriggs**4/22/48* (Address) *600 N. Arlington* M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOV

*mt. Allum Cemetery*

20 UNDERTAKER

*Walter B. Spriggs*

Date of Burial

*4/25 1948*

ADDRESS

*109 W. H. Spriggs*



E 33230

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33230

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2508 Fleet Street

ST. 1-3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WILLIAM D. FAHRMAN

(a) RESIDENCE No. 2508 Fleet Street

(Usual place of abode)

41

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 41

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White.

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Mary M. Fahrman

DATE OF BIRTH (month, day, and year) April 30, 1865

AGE

Years

62

Months

11

Days

23

If LESS than  
1 day, hrs  
or min

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Linthicum Stone Works.

BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER Martin Fahrman

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known  
(State or country)Informant Mrs. Mary Warner (Daughter)  
(Address) 2508 Fleet Street

Filed

1928

C. MARSHALL JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1928

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1928, to April 23, 1928.

that I last saw him alive on April 18, 1928.

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chimer

(Signed) J. K. Insley, M. D.

(Address) 2888 S. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Most Holy Redeemer Cemetery

DATE OF BURIAL

Apr. 26, 1928

20 UNDERTAKER

Henry Sander &amp; Sons Inc

BALTIMORE ST.  
& BROADWAY.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33231

## CERTIFICATE OF DEATH.

90 E 33231

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 579 S-6 Chapel St., 2-4 Ward)2-FULL NAME John Zaczek(a) RESIDENCE NO. 579 S-6 Chapel St., \_\_\_\_\_ Ward \_\_\_\_\_Length of residence in city or town where death occurred 26 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) July 18757 AGE 53 Years \_\_\_\_\_ Months 9 Days \_\_\_\_\_ IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Poland  
(State or country) \_\_\_\_\_10 NAME OF FATHER Frank Zaczek11 BIRTHPLACE OF FATHER (city or town) Poland  
(State or country) \_\_\_\_\_12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) Poland  
(State or country) \_\_\_\_\_14 Informant John Zaczek Jr.  
(Address) 519 S-6 Chapel15 Filed PR 25 1928 19 HARRISON JONES, JR.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, autopsy or inquiry.)and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Stenosis

## CONTRIBUTORY (Secondary)

Chorea (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
2/28/28 (Address) 143 N. 8th M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Mary Kasany April 26 192820 UNDERTAKER F. W. Gajewski ADDRESS Eastern Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33232

## CERTIFICATE OF DEATH.

90 E 33232  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5628 Woodlawn St. 76-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Robert Juty(a) RESIDENCE No. 5628 Woodlawn St.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred Life mos.

ds.

How long in U. S., if of foreign birth? Life mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhitea If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) 4-30-1918

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.✓91124

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Balto10 NAME OF FATHER Walter S Juty11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Balto12 MAIDEN NAME OF MOTHER Victoria Hochhaus13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)BaltoInformant  
(Address)Walter S Juty  
5628 Woodlawn St.

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1928

17

HEREBY CERTIFY, That I attended deceased from  
April 6, 1928, to April 24, 1928,that I last saw him alive on April 23, 1928and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH\* was as follows:

Hypertensive Pneumonia(duration) yrs. mos. 2 ds.CONTRIBUTING  
(Secondary)Delirium (duration) yrs. 12 mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alvin B. Leeman, M. D.  
4-27-1928 (Address) 711 N. Pat. Chan

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOYAL

20 UNDERTAKER

ADDRESS

John J. Kerr156 N. Luzerne

E 33233

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33233

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Chuck Home & Joyway*)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## WARD

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced /  
husband of  
(or) WIFE of

Sam'l. H. Helfrich

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

54

4

21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Balt. Co.  
Md.

10 NAME OF FATHER

Oregon R. Benson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)B. A. Co.  
Md.

12 MAIDEN NAME OF MOTHER

Cecilia Bryan

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)B. A. Co.  
Md.14 Informant  
(Address)Sam'l. H. Helfrich  
Catonville, Md.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/24 1928

17

I HEREBY CERTIFY, That I attended deceased from  
4/16/1928, to 4/24 1928,

that I last saw her alive on 4/24 1928,

and that death occurred, on the date stated above, at 12:55 a.m.

The CAUSE OF DEATH\* was as follows:

Adynamic ileus

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Chronic Cholecystitis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? yes Date of 4/17/28

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Donald A. Co.

M. D.

19

(Address)

Chuck Home &amp; Joy.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Cedar Hill Cemetery

Apr 26 1928

FUNERAL

Sam'l. Whitehall &amp; Sons 1700 Canton Ave

PR 25 1928

Register



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33234

E 33234

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE:

St. 13 Ward 58

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Abraham

6 DATE OF BIRTH (month, day, and year)

1877

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

51

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Isaac Snyder

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Nettie Harris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

Abraham Harris  
2618 Loyola Northway

15

Filed....., 19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24, 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Hidradenoma of the breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. H. M. D.

(Coroner)

(Address)

1532 Roland

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Hebrew Rose Dale 4/25, 1928

UNDERTAKER

ADDRESS 1127

Sol Furman + Bow E Balto St

E 33235

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1917 E 33235

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Colonial Hosp 14-20* Ward)2-FULL NAME *Pearl W. Davis*(a) RESIDENCE NO. *543 Laureus* St. \_\_\_\_\_ Ward \_\_\_\_\_Length of residence in city or town where death occurred *11* yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Susie Davis* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 28-1892*7 AGE Years *35* Months *10* Days *22* IF LESS than 1 day.....hrs. or.....min.8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work *Stenographer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Ayrton S. Co.* (State or country)10 NAME OF FATHER *Wm Davis*11 BIRTHPLACE OF FATHER (city or town) *S. C.* (State or country)12 MAIDEN NAME OF MOTHER *McKinnon*13 BIRTHPLACE OF MOTHER (city or town) *S. C.* (State or country)14 Informant *Susie Davis* (Address) *543 Laureus*15 Filed *PR 23 1928* REGISTRAR *JOHN H. KELSON*

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 21* 192817 I HEREBY CERTIFY, That I took charge of remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.)

And that said deceased came to death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Hemorrhage due to Bullet wound of Abdomen & Neck* (duration) \_\_\_\_\_ yrs. mos. *Chas.*

CONTRIBUTORY (Secondary)

(Signed) *J. E. Link* M. D. (Coroner)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL *mt Auburn Cemetery* Date of Burial *April 25, 1928*20 UNDERTAKER *Thomas G. Kelson*ADDRESS *1303*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33236

## CERTIFICATE OF DEATH

129 E 33236  
REGISTERED NO.1-PLACE OF DEATH *2808*City of BALTIMORE: (No. *2008 Mosher St. 16-68* Ward)2-FULL NAME *John Leon Brown*(a) RESIDENCE NO. *2808 Mosher St.* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. *0* mos. *0* ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Zenobia C Brown*6 DATE OF BIRTH (month, day, and year) *Sept 2 1879*7 AGE Years *48* Months *7* Days *23* IF LESS than 1 day... hrs. or min..8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work *Clerk in Grocer*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Store of*  
(c) Name of employer *F. Hoffman*9 BIRTHPLACE (city or town) (State or country) *Arnold Md*10 NAME OF FATHER *Franklin H Brown*11 BIRTHPLACE OF FATHER (City or town) (State or country) *Mellenville Md*12 MAIDEN NAME OF MOTHER *Jallie Stallings*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Arnold Md*14 Informant *Mr Franklin H Brown* (Address) *Glenburn Md*15 Filed *25 1928* *John H. Denny* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 23* 19*28*17 I HEREBY CERTIFY, That I attended deceased from *Jan 27*, 19*27*, to *Apr 23*, 19*28*, that I last saw *him* alive on *Apr 22*, 19*28*, and that death occurred, on the date stated above, at *310* A. M.The CAUSE OF DEATH\* was as follows: *Chronic Glomerulonephritis*CONTRIBUTORY (duration) *2* yrs. *0* mos. *0* ds.  
(Secondary) *Varicella*18 Where was disease contracted (duration) *1* yrs. *0* mos. *0* ds.  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Pathology, Clinical Study*(Signed) *Wm. H. Denny* M. D.(Address) *1013 Poplar Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*Asbury Church Cemetery Arnold Md* *April 25 1928*20 UNDERTAKER *John H. Denny* ADDRESS *715 Light St*

E 33237 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33237

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home &amp; Infirmary

CITY OF BALTIMORE: (No.

Broadway &amp; Tenth St., 27-48 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Katherine Westenhof

(a) RESIDENCE NO.

5507 Narcissus Ave. ST., 5000 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 9, 1889

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39

2

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md

10 NAME OF FATHER

Albert Gumpman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Susan J. Tzol

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

William Westenhof 5507 Narcissus Ave

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 24, 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 15, 1928, to April 24, 1928,

that I last saw her alive on April 24, 1928,

and that death occurred, on the date stated above, at 12:30 A. M.

The CAUSE OF DEATH\* was as follows:

Myoma uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Intestinal obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of April 29, 1928

Was there an autopsy? No

What test confirmed diagnosis?

Clinical

(Signed)

George B. Brill, M. D.

, 19

(Address)

Church Home &amp; Infirmary

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Druid Ridge

April 22, 1928

20 UNDERTAKER

George J. Smith

ADDRESS 1532

Hollins



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33238

## CERTIFICATE OF DEATH.

### I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 W Mulberry ST. 4 WARD)

REGISTERED No. 228

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 1317 N. Mulberry ST., \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
-------	-----------------	--

Male White Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 1939

7 AGE	Years <u>8</u>	Months	Days	IF LESS than 1 day, .... hrs or .... min.
	<u>69</u>	<u>7</u>	<u>7</u>	

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Refused

(b) General nature of industry, business, or establishment in which employed (or employer) *Iron Moulder*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)

10 NAME OF FATHER *James A. Turner*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *London*

12 MAIDEN NAME OF MOTHER *Katherine*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *London*

14 Informant Jennie Tatum  
(Address) 1317 W. 1st St.

Filed \_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4, 23 1928

17  
I HEREBY CERTIFY, That I attended deceased from  
3, 24, 1928, to 4, 23, 1928

that I last saw him *live* on. *4.23* *1948*

and that death occurred, on the date stated above, at 3.45 P.M.

The CAUSE OF DEATH\* was as follows:

the CAUSE OF DEATH was as follows:

*Pneumo. Pneumonia*

CONTRIBUTORY (Secondary) *State* (duration) yrs. mos *4* da.

(duration) 10 yrs. ~~8~~ mos. da

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *W* Date of

**Was there an autopsy?**

What test confirmed diagnosis?

(Signed) \_\_\_\_\_ M.D.

4.24 1978 (Address) 211 N. Kameoka St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
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MOVAL *Hollam* April 26, 1924

NO	UNDERTAKER	ADDRESS
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George J. Smith Hollins

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33239

## CERTIFICATE OF DEATH.

54 E 33239

## 1-PLACE OF DEATH

BALTIMORE CITY HOSPITAL  
CITY OF BALTIMORE: (No. 5-8 ST. 5-8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace D. Leved(a) RESIDENCE NO. 669 Stirling ST. 5-8 WARD 5-8

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced HUSBAND of or WIFE of Marcellus D. Leved7 DATE OF BIRTH (month, day, and year) ?  
AGE Years Months Days If LESS than 1 day, hrs. or min. 30

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) 031  
(c) Name of employerBIRTHPLACE (city or town) (State or country) Water Caroline

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant (Address) RecordsFiled 19 25 1928 U. S. DEPT. OF HEALTH JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/ 19 28

17

I HEREBY CERTIFY, That I attended deceased from Mar. 29, 1928 to April 20, 1928 that I last saw him live on April 20, 1928 and that death occurred, on the date stated above, at 8:00 P. M. The CAUSE OF DEATH\* was as follows:Pellagra(duration) yrs. 2 mos. ds.CONTRIBUTORY Pneumonia (Secondary) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? General & Sub(Signed) C. J. Jones (Address) Baltimore City Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Walden M.C. April 20, 1928  
20 UNDERTAKER Edward Bryan ADDRESS 1681 Orleans St

E 33240

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31 E 33240

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 305 S. Ann

2-FULL NAME THOMAS DROZD,

(a) RESIDENCE NO. 305 S. Ann

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. da.

St. Ward

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced. (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Unknown,

Days

IF LESS than  
1 day hrs.  
or min..

21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Moltgrafte operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore,  
MD.

## 10 NAME OF FATHER

Michael Drozd,

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

Poland,

12 MAIDEN NAME OF MOTHER Rozalia Bogdan,

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Poland,

14

Informant  
(Address)Michael Drozd,  
305 S. Ann Street

15 Filed

J. J. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 23 - 1925

19

I HEREBY CERTIFY, That I attended deceased from  
March 6, 1925, to April 23 - 1925that I last saw him alive on April 24 - 1925  
and that death occurred, on the date stated above, at 11:30 p.m.  
The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Infection.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

7 Wks - da.

(duration)

yrs.

1 mos. da.

18 Where was disease contracted

if not at place of death? ☒Did an operation precede death? no Date of ☒Was there an autopsy? ☒

What test confirmed diagnosis?

(Signed)

19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Stanislaus.

Date of Burial

20 UNDERTAKER

M. J. Sadowski

ADDRESS

305 S. Ann St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33241

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *9-46* WARD)2-FULL NAME *Erma Joyce Schaffer*(a) RESIDENCE No. *1912 East 31 st.*Length of residence in city or town where death occurred *3* yrs. *4* mos. *11* ds.ST. *9-46* WARD

REGISTERED NO. *E 33241*  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Dec. 13, 1924*

7 AGE

Years

*3*

Month

*4*

Days

*11*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore Maryland*

10 NAME OF FATHER

*Geo. J. Schaffer*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balti. Md.*

12 MAIDEN NAME OF MOTHER

*Erma Day*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balti. Md.*

Informant (Address)

*Geo. J. Schaffer 1912 E. 31st St.*

Filed

R 25 1928

HAMILTON JONES, JR.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 24 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 13*, 1928, to *April 24*, 1928, that I last saw her alive on *April 24*, 1928, and that death occurred, on the date stated above, at *10 23* p. m.

The CAUSE OF DEATH\* was as follows:

*Measles*

(duration) yrs. mos. ds.  
 CONTRIBUTORY (Secondary) *Blindness*

(duration) yrs. mos. ds.  
 18 Where was disease contracted if not at place of death? *At home*

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *None*(Signed) *Dr. J. R. Levin*, M. D.4-25-1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

UNDER TAKER

DATE OF BURIAL

ADDRESS

*Parkwood Cem*  
*Dr. J. R. Little*

PR 27 1928



E 33242

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 ✓ E 33242

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2241 Cecil ave ST. 9-46 WARD)

## 2-FULL NAME

Harry J. Flaherty

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

2241 Cecil ave

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE

Mary A Flaherty

DATE OF BIRTH (month, day, and year)

AGE 66 Years — Months 9 Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 18, 1928, to April 24, 1928, that I last saw him alive on April 24, 1928, and that death occurred, on the date stated above, at 120 P. m.

The CAUSE OF DEATH\* was as follows:

Abdominal Carcinoma  
Primary in left kidney region(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 25, 1928Was there an autopsy? NoWhat test confirmed diagnosis? exam

(Signed)

Thurston C. Knapp, M. D.Apr 18 1928 (Address) 1716 E. Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Vincent CemeteryGeorge Schilling & SonsApril 26 192811262 Mount St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33243

## CERTIFICATE OF DEATH

46 ✓ E 33243

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1319 Wilcox St. 4-18 Ward)2-FULL NAME Mary E. McLain(a) RESIDENCE NO. 1319 Wilcox

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 da. (If non-resident give city or town and State) How long in U. S. If of foreign birth: 20 yrs. 0 mos. 0 da.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced Widowed of George F. McLain (or) WIFE of6 DATE OF BIRTH (month, day, and year) March 18 18927 AGE Years 36 Months 1 Days 6 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Stafford Co Md. (State or country)10 NAME OF FATHER Thomas A. Shanahan11 BIRTHPLACE OF FATHER (City or town) Stafford Co. Md. (State or country)12 MAIDEN NAME OF MOTHER Elizabeth Quinn13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant Mr. George F. McLain (Address) 1319 Wilcox St.15 Filed 25 1928 19 25 Registrar [Signature]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 192817 I HEREBY CERTIFY, That I attended deceased from Mary E. McLain, 1928, to April 24 1928, that I last saw her alive on April 24 1928, and that death occurred, on the data stated above, at 12:45 P. m.

The CAUSE OF DEATH\* was as follows:

Recurrent carcinoma(duration) 6 yrs. 0 mos. 0 da.CONTRIBUTORY Trauma (Secondary)(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of about 1 year agoWas there an autopsy? no

What test confirmed diagnosis?

(Signed) S. Lee Wagness M. D.Date 4/24 1928 (Address) 1206 E. Weston

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

New Cathedral Cemetery Apr. 27 1928

20 UNDERTAKER

ADDRESS

Henry Hoek Son 1301 E. Eager St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33244

## CERTIFICATE OF DEATH.

90 E 33244

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1023 Jenkins St. 11-24 Ward)

## 2-FULL NAME

Rosie E Dwyer

## (a) RESIDENCE NO.

1023 Jenkins St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

Col

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofHarry Dwyer

## 6 DATE OF BIRTH (month, day, and year)

May 10 - 1852

## 7 AGE

76 Years11 Months12 Days3 IF LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Landlady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Ind.

(State or country)

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)Sarah Dwyer  
1023 Jenkins St.

## 15 Filed

25 1928May 10 1928

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Chronic Endocarditis(duration) one yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Chronic Rheumatism(duration) one yrs. mos. ds.

(Signed)

Apr 24th

(Address)

Robert M. Dwyer

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial

St. George's Apr 26 1928

20 UNDERTAKER ADDRESS

Samuel Hunsley

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33245

## CERTIFICATE OF DEATH

129 E 33245  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Provident Hospital 11-24)

## 2-FULL NAME

Louis Chaney

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

413 W Riddle

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

Colored

## 5 Single, Married, Widowed, or Divorced, write the word

Unknown

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

18 60

## 7 AGE

68

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Retired Soldier

9 BIRTHPLACE (city or town)  
(State or country)

Md

## 10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

## 14

Informant  
(Address)

Mrs. McCoy

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

4-21 1928

## 17

I HEREBY CERTIFY, That, I attended deceased from  
4-17-28, 19, to 4-21-28, 19that I last saw him alive on 4-20-28, 19  
and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH\* was as follows:

Uremia

CONTRIBUTORY (duration) yrs. mos. ds.  
(Secondary) nephritis

6 (duration) 4 yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings  
(Signed) Ernest C. Miller, M. D.  
12001 Am. av.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19-PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

UNDERTAKER

W. C. Campbell 4/25/28  
Summit Funeral Home

R 25 1928

JONES, R. H. Registrar



E 33246

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100 E 33246  
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1336 W North Ave* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Coral Hamilton*(a) RESIDENCE. NO. *1336 W North* ST., *an* WARD.  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 6-1869*7 AGE Years *69* Months *2* Days *17* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto*  
*Frederick Hamilton*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto*  
*Mary Roseman*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto*  
*John L. Hamilton*14 Informant (Address) *1336 W North*15 Filed *1928* *19* *HAMILTON JONES* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-23* 19*28*17 I HEREBY CERTIFY, That I attended deceased from *4-19*, 19*28*, to *4-23*, 19*28*, that I last saw him alive on *4-23*, 19*28*, and that death occurred, on the date stated above, at *D* m.

The CAUSE OF DEATH\* was as follows:

*Bronchial Pneumonia*CONTRIBUTORY (Secondary) *Bronchial Asthma* (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chubel*(Signed) *J. H. Jones* M. D., 19*28* (Address) *117 W. Saratoga St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*National**April 20, 1928**Maryle G. Gouthrope**Raynor*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33247

## CERTIFICATE OF DEATH.

E 33247

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 437 N. Glover St., 6 Ward)2-FULL NAME Elizabeth Wagner(a) RESIDENCE NO. 437 N. Glover St. 6 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Michael Wagner6 DATE OF BIRTH (month, day, and year) Jan 11 - 18557 AGE Years 73 Months 3 Days 12 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany  
(State or country)10 NAME OF FATHER Thomas Schaffer11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Don't know13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Lawrence Wagner  
(Address) 437 N. Glover St.

15 Filed....., 19

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 192817 I HEREBY CERTIFY, That I, attended deceased from NO 7 -, 1927, to April - 24 -, 1928, that I last saw him alive on April 24 -, 1928, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach  
(duration) ..... yrs. 5 mos. .... ds.CONTRIBUTORY (Secondary) Inflammatory Carcinoma Metastatic  
(duration) ..... yrs. 3 mos. .... ds.

18 Where was disease contracted

If not at place of death? ☒Did an operation precede death? no Date of.....Was there an autopsy? noWhat test confirmed diagnosis? no(Signed) Frank B. O'Brien, M. D.  
, 19 (Address) 125 S. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Redeemer Cem April 27 1928

20 UNDERTAKER

Lilly & Zulu Inc.

ADDRESS

403 S. W. 10

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33248

## CERTIFICATE OF DEATH.

E 33248

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *70-72* WARD)2-FULL NAME *Mary Rider*(a) RESIDENCE NO. *558 S. Bentalon*

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 16, 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

*5**8**8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*10 NAME OF FATHER *Nelson Rider*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balt. Md.*12 MAIDEN NAME OF MOTHER *Carrie Lee*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balt. Md.*

4

Informant

(Address)

*Mrs. Nelson Rider 558 S. Bentalon St.*

5

Filed

19

*C. H. JONES, JR.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 24, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 17, 1928* to *April 24, 1928*,that I last saw her alive on *April 24, 1928*, and that death occurred, on the date stated above, at *10:30 p. m.*

The CAUSE OF DEATH\* was as follows:

*Tonsillar & Pharyngeal Diphtheria*(duration) \_\_\_\_ yrs. \_\_\_\_ mos. *13* ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. *?* ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*Bacteriological*(Signed) *Dr. J. R. Levin*, M. D.4-25, 1928 (Address) *Sydenham Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

*Loudon Park*

DATE OF BURIAL

*April 25, 28*

UNDERTAKER

*Harry H. Nitzke*

ADDRESS

*153 W. Lombard*

E 33249

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33249

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4610 Elbrook Ave. Lanesville) (WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles H. Coleman

(a) RESIDENCE. No. 4610 Elbrook Ave. Lanesville

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Late Sarah R. Coleman

6 DATE OF BIRTH (month, day, and year) July 15, 1859

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 68 7 8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bald.

## 10 NAME OF FATHER

John Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bald.

## 14

Informant (Address) Mrs. May Hutchinson 4610 Elbrook Ave. Lanesville

## 15

Filed 1928 19 C. H. JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Apr. 19, 28, to Apr. 23, 28.

that I last saw him alive on Apr. 22, 28.

and that death occurred, on the date stated above, at 24. m.

The CAUSE OF DEATH\* was as follows:

Acute Diffuse Nephritis  
Pleurisy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Dilated Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 120 Date of

Was there an autopsy? 120

What test confirmed diagnosis?

(Signed) Henry A. Gorg, M. D.

25 1928 Address: Harford Rd. &amp; Schuffe St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Landon Park Cemetery April 26 1928

## 20 UNDERTAKER

Sperry - f Ruth 1735 Harford Ave



E 33250

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33250

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bon Secours Hospital* ST. *31* WARD)2. FULL NAME *Rev Michael Jos. Gorey*(a) RESIDENCE NO. *St Charles College* *Cathonsville* ST. *31* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *11* yrs. *1* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**white**Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) *Mar. 17 1897*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*31**1**7*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Priest*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Professor*

(c) Name of employer

*St Marys Seminary*

BIRTHPLACE (city or town) (State or country)

*Alsomisleye**Czecho-Slovakia*

10 NAME OF FATHER

*Michael Gorey*

11 BIRTHPLACE OF FATHER (city or town)

*Alsomisleye*

(State or country)

*Czecho-Slovakia*

12 MAIDEN NAME OF MOTHER

*Mary Vassel*

13 BIRTHPLACE OF MOTHER (city or town)

*Czecho-Slovakia*

(State or country)

Informant

*Rev John F. Fenlon*

(Address)

*St Marys Seminary*

FILED

G. H. JONES, JR.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 24 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 8*, 1928, to *Apr 24*, 1928.that I last saw him alive on *Apr 24*, 1928.and that death occurred, on the date stated above, at *8:15 A* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis with severe hemorrhages*(duration) yrs. mos. ds. *30*CONTRIBUTORY *Tbc Pneumonia*

(Secondary)

(duration) yrs. mos. ds. *15*

18 Where was disease contracted

if not at place of death? *at home*Did an operation precede death? *No* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*

(Signed)

*George O. Eaton*

M. D.

, 19 (Address) *Bon Secours Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St Marys Seminary**April 26 1928*

20 UNDERTAKER

ADDRESS

*Henry H. Jenkins & Sons**2000 N. Charles St*

E 33251

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 74 E 33251

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 W Franklin 27-43 Ward)2-FULL NAME Annie Turner(a) RESIDENCE NO. 2326 Shaffer Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life time yrs.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas H. Turner6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. about 72?

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Homework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Edw Rosch11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant John Turner (Address) 2326 Shaffer Ave15 C. HARRISON JONES M. D. Registrar RRH

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25th 192817 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.  
The CAUSE OF DEATH\* was as follows:Apoplexy (duration) Sudden yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) J. C. Lutz M. D. (Coroner) with Ann Brown

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Queen Catholical Cent Date of Burial 4-26 192820 UNDERTAKER H. R. RuckADDRESS 6405 Jefferson

E 33252

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33252

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *2008 Ellsworth* St. *8-17* Ward)

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Novotny*(a) Residence No. *2008 Ellsworth* St. .... Ward. ....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *35* yrs. .... mos. .... ds.How long in U. S. if of foreign birth? *50* yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *white*5-~~Single~~ *Married*  
Married,  
Widowed,  
or Divorced.  
(Write the word)5a-If married, widowed, or divorced,  
HUSBAND of (or) WIFE of *William Novotny*6-DATE OF BIRTH (month, day and year) *Apr 24 1873*7-AGE, *54* yrs. .... mos. .... ds. .... hrs. or .... min.?

If LESS than 1 day,

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work. *Housewife*(b) General nature of industry,  
business, or establishment in  
which employed (or employer) *637*

(c) Name of employer. ....

9-BIRTHPLACE (city or town), *Bohemia*  
(State or Country).10-NAME OF  
FATHER, *Joseph Schramke*11-BIRTHPLACE  
OF FATHER (city or town), *Bohemia*  
(State or Country).12-MAIDEN NAME  
OF MOTHER, *Not Known*13-BIRTHPLACE  
OF MOTHER (city or town), *Bohemia*  
(State or Country).

11-

(Informant) *Mary Schmitt*(Address) *1800 J. N. Chester St.*

13-

Filed *5-19-28**C. MASTON JONES, M. D.*  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *Apr 24 1928*17- I HEREBY CERTIFY, That I attended deceased from  
*Apr. 19 1928* to *Apr. 24 1928*  
that I last saw him alive on *Apr. 24 1928*  
and that death occurred, on the date stated above, at *7:30 A. M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY *arterio sclerosis*  
(Secondary)(Duration) *5* yrs. .... mos. .... ds.18-Where was disease contracted  
If not at place of death? ....Did an operation precede death? *No* Date of ....Was there an autopsy? *No*What test confirmed diagnosis? *Physical Exam.*(Signed) *Joseph Schramke* M. D., 19 *28* (Address) *28 W 25 St.*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL *Holy Redeemer*DATE OF BURIAL, *Apr. 26 1928*20-UNDERTAKER, *Paul Brackner*ADDRESS *1906 Broadway*

E 33253

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33253

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 714 N. PortSt. 7-12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Barock(a) RESIDENCE NO. 714 N. Port St

(Usual place of abode)

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteInfant5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 1926

7 AGE

Years

Months

Days

IF LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min..218

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Infant

9 BIRTHPLACE (city or town)

(State or country)

Balto.

10 NAME OF FATHER

Joseph Barock

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Balto.

12 MAIDEN NAME OF MOTHER

Anna Maronick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto.

14

Informant  
(Address)Joseph Barock  
714 N. Port St

15 Filed

6 MAY 1926  
Dr. J. H. Jones  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28

17

I HEREBY CERTIFY, That I attended deceased from

4-17-28, 19\_\_\_\_, to 4-24-28, 19\_\_\_\_.that I last saw him alive on 4-24-28, 19\_\_\_\_.and that death occurred, on the date stated above, at 230-A m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

CONTRIBUTORY

(Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? \_\_\_\_ Date of \_\_\_\_

Was there an autopsy? \_\_\_\_

What test confirmed diagnosis? \_\_\_\_

(Signed) \_\_\_\_

M. D.

\_\_\_\_, 19\_\_\_\_

(Address) \_\_\_\_

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Holy Redeemer  
Frank GracklarApril 26 1928  
1400 Ashland



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33254

## CERTIFICATE OF DEATH

129 E 33254  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3411 Talbot St. St. 12-49 Ward 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Jones(a) RESIDENCE NO. 3411 Talbot St. St. 12 Ward 49

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard Jones6 DATE OF BIRTH (month, day, and year) June 2nd 18807 AGE Years 47 Months 10 Days 20 IF LESS than 1 day...hrs. or...min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Glenester Co. Va. (State or country)10 NAME OF FATHER John Gainer11 BIRTHPLACE OF FATHER (City or town) Va. (State or country)12 MAIDEN NAME OF MOTHER Charlotte Halmer13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)14 Informant Mary Jones (Address) 3411 Talbot St.15 Filed 5 1928 C. H. JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22nd 192817 I HEREBY CERTIFY, That I attended deceased from Feb 17th 1928 to April 22nd 1928, that I last saw her alive on April 22nd 1928 and that death occurred, on the date stated above, at 1010 P. M.

The CAUSE OF DEATH\* was as follows:

Endocarditis & MyocarditisCONTRIBUTORY (duration) 1 yrs. 0 mos. 0 ds. (Secondary) Coronary atherosclerosis(duration) 8 yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Examination(Signed) Geo. W. Montgomery, M. D.4/23/28 (Address) 401 E 25th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Glenester Co Va

UNDERTAKER

Mrs. R. G. Elliott

ADDRESS

125 Ashland

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33255

## CERTIFICATE OF DEATH.

66 E 33255

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital* St. *10-2* Ward *2*)2-FULL NAME *John J. Finn*(a) RESIDENCE NO. *202-1-3<sup>rd</sup>* St. *10-2* Ward *2*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. da.

How long in U. S. If of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 Color of Race *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed or divorced HUSBAND of (or) WIFE of *Anna J. Finn*6 DATE OF BIRTH (month, day, and year) *Jan. 27-1869*

7 AGE

Years *59*Months *3*Days *3*

IF LESS than 1 day...hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*(b) General nature of industry, business, or establishment in which employed (or employer) *City of Baltimore*(c) Name of employer *City of Baltimore*9 BIRTHPLACE (city or town) *Baltimore Md*

(State or country)

10 NAME OF FATHER *David Finn*11 BIRTHPLACE OF FATHER (city or town) *Ireland*

(State or country)

12 MAIDEN NAME of MOTHER *Margaret Welch*13 BIRTHPLACE OF MOTHER (city or town) *Ireland*

(State or country)

14

Informant *Anna J. Finn*(Address) *202 South 3<sup>rd</sup> St*15 Filed *1928*16 *MAJESTY JONES* Registrar

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 14 1928*17 I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Alcoholism*

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. da. *1*(duration) yrs. mos. da. *1*(signed) *G. C. Blahut* M. D.

(Coroner)

19 (Address) *1436 Bway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL *U.S. National*Date of Burial *7/27/28*20 UNDERTAKER *Wm Cook*ADDRESS *504 E. N. Ave*

33256

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

ST. 12-19 WARD)

## 2-FULL NAME

WILLIAM SIDNEY KRATZ

(a) RESIDENCE NO.

1812 Barclay St

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Keza M. Kratz

6 DATE OF BIRTH (month, day, and year)

Sept 30, 1875

7 AGE

Years

Months

Days

If LESS than

1 day, ... hrs.

or min.

52

6

24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Freight Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Penn R.R.

9 BIRTHPLACE (city or town) (State or country)

West Va

10 NAME OF FATHER

Thomas Kratz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Anna Leathers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

West Va

14

Informant (Address)

Keza M. Kratz 1812 Barclay St

15

Filed

G. H. HANCOCK, JR., M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 24 1928

17

I HEREBY CERTIFY, That I attended deceased from

11-21-28, 19, to 4-24-28, 19,

that I last saw him alive on 4-24-28, 19,

and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park

Apr 26 1928

H. M. Cook

502 E North Ave

E 33257

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33257

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2427 Georgetown Rd 25-72 WARD)2. FULL NAME Adam Hanzler(a) RESIDENCE NO. 2427 Georgetown Rd ST.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Rose Hanzler

6 DATE OF BIRTH (month, day, and year)

August 2, 1863

7 AGE

Years 64Months 8Days 22

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

Fulbright

(c) Name of employer

B & O.

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Johannes Hanzler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

1

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Mary Kemp2427 Georgetown Rd

15

1928

19

JAMES JONES, JR.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 192817 I HEREBY CERTIFY, That I attended deceased from April 8, 1928 to April 24, 1928, that I last saw him alive on April 24, 1928 and that death occurred, on the date stated above, at 1:45 P. M. The CAUSE OF DEATH\* was as follows:Chronic Myocarditis(duration) 2 yrs. mos. ds.CONTRIBUTORY (Secondary) Arteriosclerosis(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) Wm. A. Strauss M. D.1/4, 1948 (Address) 1201 Zippis Ave  
State the Disease Causing Death, or death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

DATE OF BURIAL

20 UNDERTAKER

Wm. Cook

ADDRESS

5028 North Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33258

## CERTIFICATE OF DEATH.

E 33258

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1216 Harford Ave.* ST. *10-14* WARD)2-FULL NAME *William F. McDaniel*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *1216 Harford Ave.* ST. *all his life* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced

HUSBAND of *Esther A. McDaniel*6 DATE OF BIRTH (month, day, and year) *Nov. 11, 1853*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*74**5**13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*10 NAME OF FATHER *Wm. H. McDaniel*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *H. Mary's Co., Md.*12 MAIDEN NAME OF MOTHER *Mary Collins*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *H. Mary's Co., Md.*

14

Informant *Esther A. McDaniel*(Address) *1216 Harford Ave.*

15

Filed *3/19/28**C. H. HANFORD JONES, M. D.*  
*R. R. H.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 24, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*January 13, 1926, to April 24, 1928.*that I last saw him alive on *April 24, 1928.*and that death occurred, on the date stated above, at *3:45 p. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic myocarditis*(duration) *2 yrs. 3 mos.* ds.CONTRIBUTORY  
(Secondary)*Pulmonary congestion*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *C. D. E. E. E.*

M. D.

*4/24/1928* (Address) *3449 Greenmount Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Carmel Cemetery 4/27/1928*

20 UNDERTAKER

*William Cook*

ADDRESS

*502 E. North Ave.*

E 33259

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 91 E 33259

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)ST. 79 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Garrett Burt Gost(a) RESIDENCE NO. Mannington W. Va.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

12 ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Myrtle

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

52.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Motorman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

W. Va.

10 NAME OF FATHER

David J.

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Myrtle

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

W. Va.

Informant

(Address)

JOHNS HOPKINS HOSPITAL

Filed

19

C. HANCOCK JONES, JR.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 24 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 13, 1928, to April 24, 1928,

that I last saw him alive on

April 24, 1928,

and that death occurred, on the date stated above, at

8:05 p.m.

The CAUSE OF DEATH\* was as follows:

Aneurysm of left middle  
cerebral artery - non-  
syphilitic

(duration) 15 yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Pneumo-pneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical &amp; operative

(Signed)

George B. Finney

M. D.

4/24/28 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Mannington W. Va. April 26 28

UNDERTAKER

William Schaeffer 1816 Mount

E 33260

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33260

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hosp. 25-32*)REGISTERED NO. *70*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Emil Howard*(a) RESIDENCE NO. *1252 - Annapolis Ave.*

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*M*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *April 24, 1924*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*1**0**0*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER *Edgar Howard*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Wilhelmina Belter*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)Filed *1928*

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 28, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 28, 1928*, to *April 28, 1928*.that I last saw him alive on *April 28, 1928*and that death occurred, on the date stated above, at *8:27 p.m.*

The CAUSE OF DEATH\* was as follows:

*Acute Encephalitis*(duration) yrs. mos. *10* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Autopsy findings*(Signed) *James Arthur Webber*, M. D.19 (Address) *Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Western Cem April 26, 1928*

20 UNDERTAKER

ADDRESS

*John C. Miller 2435 E Oliver St*

9463  
133261

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 33261

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)ST. 6-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Frank Schultz

(a) RESIDENCE NO.

30 W. StreeterST. 6-11 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteMarried

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofCarrie

DATE OF BIRTH (month, day, and year)

3-12-76

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.52

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Ind -

10 NAME OF FATHER

George

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Anna

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant

Records -

(Address)

JOHNS HOPKINS HOSPITAL

Filed

5 1928

19

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar - 26, 1928, to April 24, 1928.that I last saw him alive on April 24, 1928.and that death occurred, on the date stated above, at 6 a - m.

The CAUSE OF DEATH\* was as follows:

Aneurysm of aortaAortic insufficiencyMyocardial insufficiency(duration) 1 yrs. 1 mos. 1 ds.CONTRIBUTORY  
(Secondary)Syphilis(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted

if not at place of death?

Not known

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy.

(Signed)

James Bradley

M. D.

4/24, 1928

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cemetery

DATE OF BURIAL

April 27

1928

ADDRESS

2512 E. Baltimore St.

20 UNDERTAKER

Frank J. Pipitone



E 33262

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33262

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 *Piscataway*)ST. *21-31* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Mary Paraway*(a) RESIDENCE NO. 1111 *Piscataway*  
(Usual place of abode)Length of residence in city or town where death occurred *54* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**Colored**Widow*6 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *June 1874*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*54*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*000*

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Balto.*

10 NAME OF FATHER

*Andrew Todd*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*md*

12 MAIDEN NAME OF MOTHER

*Clara Paraway*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*md*Informant  
(Address)*Nancy Opie**1031 N. Carey St.*

Filed

19

*MAHMOUD JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 22 1928*

17

I HEREBY CERTIFY that I attended deceased from  
*Feb 10*, 19*28*, to *April 22*, 19*28*,  
that I last saw him alive on *April 22*, 19*28*,  
and that death occurred, on the date stated above, at *7:30 P* m.

The CAUSE OF DEATH\* was as follows:

*Basal Carcinoma*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

M. D.

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

*St. Peter's Am*

20 UNDERTAKER

*John H. Toddman*

DATE OF BURIAL

*4-26-1928*ADDRESS *1027**Wood Hill*

33263

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33263

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1120 N. Carrollton Ave* ST. *16-23* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Bessie Bowman*

## (a) RESIDENCE NO.

*1120 N. Carrollton Ave*

## WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*7* yrs. — mos.

— ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*Caf*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*married*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*James Bowman*

## 6 DATE OF BIRTH (month, day, and year)

*Nov-22-1904*

## 7 AGE

Years

*23*

Months

*5*

Days

*2*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

*Housewife*

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Shelburne Co. Virginia*

## 10 NAME OF FATHER

*Doc Jessor*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Shelburne Co. Virginia*

## 12 MAIDEN NAME OF MOTHER

*Mary Duval*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Shelburne Co. Virginia*

## 14

Informant (Address)

*James Bowman 1120 N. Carrollton Ave*

## 15

Filed

*HARRISON JONES, Jr. Registrar*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*4 / 24 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from *3/1* 1928 to *7/24* 1928.that I last saw him alive on *4/23* 1928.and that death occurred, on the date stated above, at *5:00 a. m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*(duration) — yrs. *4* mos. — ds.

## CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical*

(Signed)

*Dan J. S. S. M. D.*

4/14, 1928

(Address) *122 - see 25*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Pendleton. Louise*

## DATE OF BURIAL

*4-26-1928*

## 20 UNDERTAKER

*John H. Toadwin*

## ADDRESS

*1027 Wind Hill*

E 33264 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33264

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *4-30* Ward)

Registered No. ....

## 2-FULL NAME

*Elva Amelia Bruehl*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) Residence No.

*Parkton, Maryland* St. .... Ward. ....

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long to U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*5-Single, Married, Widowed, or Divorced. (Write the word) *Married*

5a-If married, widowed, or divorced

*HUSBAND of* WIFE of *Howard Bruehl*

6-DATE OF BIRTH (month, day and year)

*12-27-1896*

## 7-AGE

*31* yrs. *3* mos. *27* ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. .... *Prof. 037*(b) General nature of industry, business, or establishment in which employed (or employer). .... *Own home*

(c) Name of employer. ....

9-BIRTHPLACE (city or town) (State or Country).

*Maryland*

## 10-NAME OF FATHER

*L. Kurtz Cullison*

## 11-BIRTHPLACE OF FATHER (city or town) (State or Country).

*Maryland*

## 12-MAIDEN NAME OF MOTHER

*Esther E. Wilhelm*

## 13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

*Maryland*

## 14-

(Informant)

*Edw. E. Nipton*

(Address)

*Hampton Md*

## 15-

Filed

*1926*

192

*MARYSON JONES*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year)

*4/24/28*

17- I HEREBY CERTIFY, That I attended deceased from

*4/23* 19*28* to *4/24* 19*28*that I last saw him alive on *4/24* 19*28*and that death occurred, on the date stated above, at *11:50 p.m.*

The CAUSE OF DEATH\* was as follows:

*Pregnancy - Nephrotic Toxemia + Premia*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Pulmonary Edema*

(Duration) yrs. mos. ds.

18-Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Phys Exam & Lab.*(Signed) *Thurston Reynolds* M. D.19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes

state (1) Means and Nature of Injury, and (2) whether Accidental

Suicidal, or Homicidal. (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

*Grace Church, Baltimore*

DATE OF BURIAL

*4-27, 1928*

20-UNDERTAKER

*Wm. J. McKee & Sons*ADDRESS *North & Remond*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33265

## CERTIFICATE OF DEATH.

E 33265

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)2-FULL NAME Betty Flint(a) RESIDENCE NO. Cumbrland, Md.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

7

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) June 13, 1925

AGE

Years

Months

Days

2

10

12

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.10 NAME OF FATHER George Flint11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.12 MAIDEN NAME OF MOTHER Laura Morris13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.Informant (Address) Mother

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1928, to April 25, 1928that I last saw her alive on April 25, 1928, and that death occurred, on the date stated above, at 3:33 p.m.

The CAUSE OF DEATH\* was as follows:

Tumor of Cerebellum(duration) 1 yrs. 3 mos. over ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 25, 1928Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. S. S. S. M. D., 19 (Address) Union Memorial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

File 1928

C. HANSON JONES, M. D. Registrar

John O. Mitchell 1928



E 33266

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33266

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1435-Pa. a* ST. *14-20* WARD)

## 2. FULL NAME

*Chas. Carroll*(a) RESIDENCE NO. *1535-Penna a*

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.ST. *14-20* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *M*4 COLOR OR RACE *C*5 Single, Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed, or divorced *Widowed* of (or) WIFE of *Naomia Carroll*DATE OF BIRTH (month, day, and year) *Dec 1875*

AGE

Years *53*Months *4*

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Saborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Howard Co Md.*10 NAME OF FATHER *Henry E. Carroll*11 BIRTHPLACE OF FATHER (city or town) *Md.*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Md.*Informant (Address) *Naomia Carroll 1935 Penna ave.*Filed *5 1928*

19

*G. H. HANCOCK JONES*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/24 1928*

17

I HEREBY CERTIFY, That I attended deceased from *3/24* 19 *28* to *4/24* 19 *28*that I last saw him live on *4/24 1928*and that death occurred, on the date stated above, at *10:25 AM*

The CAUSE OF DEATH\* was as follows:

*Acute Gasping*(duration) yrs. / mos. / *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No*

Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Wm. C. Chitt*(Address) *212 O St*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Asbury Cemetery Howard Co Md*DATE OF BURIAL *Apr. 26 1928*20 UNDERTAKER *Thomas E. Kelown*ADDRESS *1303*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33267

## CERTIFICATE OF DEATH

REGISTERED NO.

E 33267

## 1-PLACE OF DEATH

City of BALTIMORE (No. 1314 Lammis St. Ward 16-23)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Tauline Trice

## (a) RESIDENCE NO.

1314 Lammis St. Ward 16-23

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Sept 29 1925

## 7 AGE

2 Years6 Months26 Days

IF LESS than 1 day hrs. or min.

374

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Infant

## 9 BIRTHPLACE (city or town)

(State or country)

City

## 10 NAME OF FATHER

Tail Trice

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Georgia

## 12 MAIDEN NAME OF MOTHER

Coral Williams

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ga

## 14

Informant (Address)

Tail Trice  
1314 Lammis St.

## 15 Filed

1926

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr 25 19 28

## 17

I HEREBY CERTIFY, That I attended deceased from

Apr 25, 19 28, to Apr 25, 19 28,that I last saw him alive on Apr 25, 19 28,and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH\* was as follows:

Robled pneumonia

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. G. Galt M. D.S. 19 28 (Address) 1204 Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

James H. Jones  
1364 Ave

E 33268

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. E 33268

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. Ward)2-FULL NAME Moses Stein(a) RESIDENCE NO. New York

(Usual place of abode)

Length of residence in city or town where death occurred

Unknown mos.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)MaleWhiteMarried

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Henrietta Stein

6 DATE OF BIRTH (month, day, and year)

About 1868.

7 AGE

Years:

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.About 60

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workSalesman(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York

(State or country)

N.Y.10 NAME OF FATHER S. Stein

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant Meyers & Co.(Address) 180 W. 76th. St. New York.

15

Filed..... 19 C. H. Jones, Jr.

Registrar

St. Ward(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25/192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-topsy or inquiry,) I find that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

A 26 (Signed) Arthur M. D.  
(Coroner), 19 28 (Address) 1039 Broadway\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Manner and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place for In the  
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL New York. Date of Burial4/26/1928

20 UNDERTAKER

David Soudheim  
ADDRESS  
118-26 W. Mt. Royal Ave.

340  
2E 33269

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57E 33269

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)ST. 9-18 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Jinker(a) RESIDENCE No. 1518 N. Annapolis  
(Usual place of abode)ST. 9-18 WARDLength of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds.(If non-resident give city or town and State)  
Now long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) marriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofRobert JinkerDATE OF BIRTH (month, day, and year) 1860AGE Years 68 Months 0 Days 0 If LESS than 1 day, hrs. 0 or min. 0

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Baltimore10 NAME OF FATHER Conrad Klemm11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Germany12 MAIDEN NAME OF MOTHER Dora Klemm13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)GermanyInformant Records(Address) JOHNS HOPKINS HOSPITAL

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25 1928

17

I HEREBY CERTIFY, That I attended deceased from April 21, 1928, to April 25, 1928, that I last saw her alive on April 25, 1928, and that death occurred, on the date stated above, at 2:45 m.

The CAUSE OF DEATH\* was as follows:

PyelitisRenal pneumonia(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

Diabetes Mellitus  
(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at homeDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

Stomach Chemistry

(Signed)

Lynne M. M. D.

4-25, 1928 (Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOALLorraine Ceen

20 UNDERTAKER

John Allen

DATE OF BURIAL

April 28 1928

ADDRESS

2008  
Chesapeake



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33270

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 33270

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Belair Road ST. 40 WARD)

## 2-FULL NAME

Rosina Thomas

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

2211 Belair Road ST. 40 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Thomas6 DATE OF BIRTH (month, day, and year) Dec 1 - 18367 AGE Years 91 Months 4 Days 25 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland10 NAME OF FATHER Don't know11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland12 MAIDEN NAME OF MOTHER Don't know13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant

(Address) Mr. Albert Cooper

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26 1928

17

I HEREBY CERTIFY, That I attended deceased from February, 1928, to April 26, 1928, that I last saw her alive on April 20, 1928, and that death occurred, on the date stated above, at 7:45 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis with history of many years duration (duration) yrs. mos. ds.CONTRIBUTORY Cardiac failure due to age (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) SWANSON M. D.19 (Address) 2020 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Western CemeteryApr 29 1928

UNDERTAKER

ADDRESS

John Ullrich2008 Belair

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33271

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2107

ST. 12 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 2105

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Aug 30, 1864

AGE

Years 63

Months 8

Days 6

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant

(Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25, 1928

17

I HEREBY CERTIFY, That I attended deceased from 4/12, 1928, to 4/25, 1928, that I last saw him alive on 4/25, 1928, and that death occurred, on the date stated above, at 1:00 a.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 12 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Daniel Miller M. D.

(Address) 1500 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 33273

## CERTIFICATE OF DEATH.

31 E 33273

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore City Hospital 73-31*)2-FULL NAME *Albert White*(a) RESIDENCE NO. *204 Stauden*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*M.**Colored**Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*9.1*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*West Indies*10 NAME OF FATHER *Wm. White*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*West Indies*12 MAIDEN NAME OF MOTHER *Catherine Brown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*West Indies*

Informant

(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4-20-1928*

17

I HEREBY CERTIFY, That I attended deceased from *2-29-1928* to *4-20-1928* that I last saw him alive on *4-20-1928*and that death occurred, on the date stated above, at *1245* m.

The CAUSE OF DEATH\* was as follows:

*Tubercular Empyema*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*Home*Did an operation precede death? *No* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*City City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

ADDRESS

Filed

1928

19

C. H. Jones, Jr.

Registrar

Baltimore Health.



E 33274

## HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ E 33274

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Byrd St

ST. 24-34 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene M. Mc Donald

(a) RESIDENCE NO. 1715 Byrd St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

John F. Mc Donald

6 DATE OF BIRTH (month, day, and year) Aug. 8 1902

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
25 8 16

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER Robert C. Miles

11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Addie Spurry

13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)4 Informant Mrs. McDonald  
(Address) 1715 Byrd St.5 26 1928  
Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 24 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1928, to April 24, 1928

that I last saw him live on April 20, 1928

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH\* was as follows:

Metabolic Regulation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart 2 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Crimally

(Signed) R. H. Campbell, M. D.

Address 1644 Hammer

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Cem

DATE OF BURIAL

Apr 27 1928

20 UNDERTAKER

J. F. Mc 6 ally

ADDRESS

1305 Fort

212<sup>343</sup>  
E 33275

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 89 E 33275

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 7-9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Maurice MacKlan

## (a) RESIDENCE NO.

Lock Raven, Md.

## WARD

(Usual place of abode)

Length of residence in city or town where death occurred

20 yrs.

5 mos.

How long in U. S., if of foreign birth?

20 yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Annie MacKlan

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Faciler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Russia

## 10 NAME OF FATHER

Harry MacKlan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Ethel ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

Informant

(Address)

Records  
JOHNS HOPKINS HOSPITAL

Filed

36 MAR 1928

Rec'd by Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 19 28

17

I HEREBY CERTIFY, That I attended deceased from March 22 19 28, to April 25 19 28, that I last saw him alive on April 28 19 28, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH\* was as follows:

Arterio sclerosis.

Myocardial insufficiency

Angina pectoris

(duration) 12 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Raymond Wire, M. D.

4/25, 1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Rehman Roseville

## DATE OF BURIAL

7/26 19 28

## 20 UNDERTAKER

Jack Lewis 1439 E. 14th St.

## ADDRESS

E. 14th St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33276

## CERTIFICATE OF DEATH

129 E 33276

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Eden ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

424 N. Eden ST.,

WARD

Length of residence in city or town where death occurred 4 1/2 yrs. mos. ds.

How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

C.

5 Single, Married, Widowed, or Divorced, (write the word)

MarriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofMary Barrett

DATE OF BIRTH (month, day, and year)

London, 1878

AGE

Years  
50

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md.

10 NAME OF FATHER

Thomas Barrett11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Md.

12 MAIDEN NAME OF MOTHER

Susan Watson13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Md.Informant  
(Address)Mary Barrett (Wife)  
424 N. Eden St.Filed 26 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 23, 1928I HEREBY CERTIFY, That I attended deceased from March 23, 1928 to April 23, 1928.that I last saw him alive on April 23, 1928.and that death occurred, on the date stated above, at 10 45 m.

The CAUSE OF DEATH\* was as follows:

Quincke's Intestinal Angitis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?noDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

J. S. Allen

M. D.

(Address)

508 Somerset St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
BURYAL

DATE OF BURIAL

Ashbury CemeteryApril 23, 1928

UNDERTAKER

ADDRESS

Thos. R. G. Elliott220 Ashland St.

E 33277

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 33277

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3130 Harford Rd. ST. 9-45 WARD)

## 2. FULL NAME

Henry Roth

## (a) RESIDENCE NO.

3130 Harford Rd

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

70 yrs. 3 mos. 10 ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frances M. Roth

## 6 DATE OF BIRTH (month, day, and year)

January 16, 1858

## 7 AGE

Years

Months

Days

If LESS than 1 day..... hrs. or..... min.

70

3

10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Secretary

(b) General nature of industry, business, or establishment in which employed (or employer)

Muller's Lys. Ins. Co.

(c) Name of employer

Muller's Lys. Ins. Co.

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

Maryland

## 10 NAME OF FATHER

John Roth

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Kuhnau

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

Informant (Address)

Mrs. Frances Roth

3130 Harford Rd

Filed

26 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1928, to April 26, 1928.

that I last saw him alive on April 26, 1928 and that death occurred, on the date stated above, at 10. m

The CAUSE OF DEATH\* was as follows:

Hypertensive, Chronic Pulmonary Disease, Nephritis, Myocarditis and acute pneumonia (Pneumonia)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Chas. P. Evans

M. D.

(Address)

2870 Harford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Holy Redeemer Cemetery

4/28/28

20 UNDERTAKER

Chas. P. Evans &amp; Son

118 W. Mt. Royal Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33278

## CERTIFICATE OF DEATH.

129  
E 33278  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 233 W. Biddle St. 11-24 Ward)

## 2-FULL NAME

Amie C. Crouse

## (a) RESIDENCE NO.

233 W. Biddle St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph J. Crouse

6 DATE OF BIRTH (month, day, and year)

Aug 4 - 1855

7 AGE

Years

72

Months

8

Days

21

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Maryland

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Miss Crouse  
233 W. Biddle

15 Filed....., 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 25 - 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 6<sup>th</sup>, 1928, to Apr 25<sup>th</sup>, 1928, that I last saw her alive on April 25<sup>th</sup>, 1928, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis (Bright's)(duration) 17 yrs. .... mos. .... ds.

CONTRIBUTORY

(Secondary)

Myocarditis & Exhaustion(duration) 5 yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

. 19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

Date of Burial

Cathedral Cemetery4/28, 28

20 UNDERTAKER

ADDRESS

Chas. F. Traut & Son 118 W. Mt. Royal Ave.

E 33279 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33279

## CERTIFICATE OF DEATH.

74-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Grantley ST. 16-67 WARD)

2-FULL NAME Elizabeth C. Chalchum

(a) RESIDENCE No. 710 Grantley ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John C. Chalchum

6 DATE OF BIRTH (month, day, and year)

Apr 31 1861

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

67 25

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Maryland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

R 26 1928 G. HADDOCK JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1928

17

I HEREBY CERTIFY, That I attended deceased from Oct 28 1927 to April 25 1928, that I last saw her alive on April 25 1928, and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage (apoplexy)

CONTRIBUTORY (Secondary)

Arterio-Sclerosis (duration) yrs. mos. 5 ds. Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D. 4/26 1928 (Address) 108 N. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cemetery

4/26/28

20 UNDERTAKER

ADDRESS

Engle &amp; Sons, 100 N. E. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33280

## CERTIFICATE OF DEATH

74 E 33280  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 5007 Eugene Ave. St. 27-1st Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 5007 Eugene Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? 2 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced. (write the word)

Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles E. Euterlet

6 DATE OF BIRTH (month, day, and year)

Nov. 22<sup>nd</sup> 1845

7 AGE

Years

Months

Days

82

4

3

IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Mr. Walch

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

(Address)

Mr. James Euterlet  
5007 Eugene Ave.

15 Filed

PR 26 1928

J. J. Jones, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 25<sup>th</sup>

1928

17

HEREBY CERTIFY, That I attended deceased from

Apr. 25, 1928, to Apr. 26, 1928,

that I last saw him alive on Apr. 25, 1928,

and that death occurred, on the data stated above, at 10:20 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Data of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

25. 1928 (Address)

Wm. J. Corcoran, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery

Apr. 28 1928

20 UNDERTAKER

ADDRESS

Henry Street

1301 E. Euterlet

E 33281

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 E 33281

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

BALTIMORE CITY HOSPITAL

ST. 27-31 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Jenny Benton

(a) RESIDENCE No.

810

Peach Alley

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male colored

5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

60

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Informant  
(Address)

Filed

2390

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 21, 1928 to Apr. 23, 1928

that I last saw him alive on Apr. 23, 1928

and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH\* was as follows:

meningitis - suppurative

(duration) yrs. mos. 7 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? General &amp; Sub

(Signed) C. Holmes O'Leary, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

APR 26 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33282

## CERTIFICATE OF DEATH.

31 E 33282

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals 22-30 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Perry(a) RESIDENCE No. 2 W. Conway st.

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 18997 AGE Years Months Days If LESS than 1 day, hrs. or min. 29

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer UnknownBIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Jim Perry11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Susie Ward13 BIRTHPLACE OF MOTHER (city or town) (State or country) VirginiaInformant Hospital Records (Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 4, 19 28, to April 25, 19 28.that I last saw him alive on April 25, 19 28.and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical & lab.(Signed) L. E. Madden M. D.4-25-1928 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

APR 26 1928

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33283

## CERTIFICATE OF DEATH.

MORE 101-001  
E 33283

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 W. Hamburg ST. 73 W. 73)

2-FULL NAME Charles Robinson

(a) RESIDENCE NO. 140 N. Hamburg ST. 21 WARD  
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. ☒ How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

10. If married, widowed, or divorced  
 HUSBAND of *Missie Robinson*  
~~WIFE of~~

DATE OF BIRTH (month, day, and year) Aug 2, 1870

AGE	Years	Months	Days	If LESS than 1 day,.....hrs or.....min.
51		3	22	

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore  
(State or country)

10 NAME OF FATHER Charles Robinson

11 BIRTHPLACE OF FATHER (city or town) London  
(State or country)

12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town) London  
(State or country)

Informant James Robertson  
(Address) 1402

Filed \_\_\_\_\_ 19\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-19

17 I HEREBY CERTIFY, That I attended deceased from  
4/11, 1928, to 7-27, 1928.  
that I last saw him alive on 4-23, 1928,  
and that death occurred, on the date stated above, at 8:25 p. m.

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 da

CONTRIBUTORY (Secondary) Robert Owen Morris

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 13 da

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? Skull x-ray

(Signed) \_\_\_\_\_

19 (Address) 709 S. ...

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL DATE OF BURIAL

116 (Larkin Co. 11/35)

2. UNDERTAKER

NAME	ADDRESS
44	

33284

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33284

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *1724* Ward)

Registered No. ....

## 2-FULL NAME

*Baby Boy Robinson*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *1114 Brewer* St. .... Ward. ....  
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*Black*5-Single,  
Married,  
Widowed,  
or Divorced,  
(Write the word.)5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

*4/22/28*

7-AGE

If LESS than 1 day,

yrs. .... mos. *2* ds.

hrs. or .... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town),  
(State or Country)*Baltimore, Md.*10-NAME OF  
FATHER*David James*11-BIRTHPLACE  
OF FATHER (city or town),  
(State or Country)*Baltimore, Md.*12-MAIDEN NAME  
OF MOTHER*Carlie Robinson*13-BIRTHPLACE  
OF MOTHER (city or town),  
(State or Country)*Howard Co - Md.*

11-

(Informant) *Carlie Robinson*  
(Address) *111 Brewer St.*

15-

Filed

PR 26 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *4/24/28*

17- I HEREBY CERTIFY, That I attended deceased from

*4/22* 19 *28* to *4/24* 19 *28*that I last saw him live on *4/24* 19 *28*and that death occurred, on the date stated above, at *4 P.M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage  
(Forceps delivery)*

(Duration) .... yrs. .... mos. .... ds.

## CONTRIBUTORY

(Secondary)

(Duration) .... yrs. .... mos. .... ds.

18-Where was disease contracted  
If not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Thight Reynolds* M. D.19 (Address) *University*\*State the Disease Causing Death, or in deaths from Violent Causes  
state (1) Means and Nature of Injury, and (2) whether Accidental  
Suicidal, or Homicidal. (See reverse side for additional space)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL

DATE OF BURIAL

*111 Brewer St. 7:26, 1928*

20-UNDERTAKER

ADDRESS

*Samuel H. Hensley M. D.*

E 33285

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Somerset ST. 10-14 WARD)

## 2. FULL NAME

Emmanuel Lepicomb

(a) RESIDENCE NO.

(Usual place of abode)

820 Somerset ST.

WARD

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Bertha (Orley) Spink

6 DATE OF BIRTH (month, day, and year)

Nov. 1873

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

54

65

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

Jr. Lepicomb

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

Informant (Address)

J. Lepicomb 917 H. Street, Va.

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

23 Apr 1928

17

HEREBY CERTIFY That I attended deceased from

Apr 23 1928 to Apr 23 1928

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH\* was as follows:

Acute Indigestion

(over)

Shower

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, If

(Address)

1511 W. Mulberry

\*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Mt. Auburn

7/27/1928

Chas. Alexander 1408 Duval St.



E 33286

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33286

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *7005 McKean Ave* ST. *15-21* WARD)2-FULL NAME *Emma J. Shelly*(a) RESIDENCE NO. *2014 McKean Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *26* yrs. mos. ds.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced  
HUSBAND of *Louisa Shelly*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Apr 18-1840*7 AGE Years *88* Months *-* Days *7* If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) *Va*10 NAME OF FATHER *John B. Shelly*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Mary Hemdon*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Unknown*Informant *Roberta Cullen*  
(Address) *2005 McKean Ave*Filed *6-19-28* 19 *HARRISON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 20-1928*17 I HEREBY CERTIFY, That I attended deceased from *Apr 18*, 1928, to *Apr 20*, 1928,that I last saw her alive on *Apr 24*, 1928, and that death occurred, on the date stated above, at *10-21 a.m.*

The CAUSE OF DEATH\* was as follows:

*Arterio Sclerosis**about* (duration) *8* yrs. mos. ds.CONTRIBUTORY (Secondary) *Myocardial degeneration*  
*about* (duration) *5* yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*O. N. Dravall*, M. D.  
*24*, 1928 (Address) *1817 N. Fulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *St. Mary's Cmn. Hampden*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Harry W. Ehlert* *1944 N. North Ave*

E 33287

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33287

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6145 Puller St. 1-3)

2-FULL NAME Foster Thompson

(a) RESIDENCE. NO. 6145 Puller St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased, from 4-25-28, 1928, to 4-25-28, 1928, that I last saw him alive on 4-25-28, 1928, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

UNDERTAKER

Commissioner of Health

ADDRESS

APR 26 1928

E 33288

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33288

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5009 Elmer Avenue

2-FULL NAME Frank A. Herold

(a) RESIDENCE NO. Bethesda, Md.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Lena Herold

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1871

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

57

1

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Owner and Trainer of

(b) General nature of industry, business, or establishment in which employed (or employer)

Horses

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER Oscar Herold

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant  
(Address)Mr. William J. Kennelly  
5009 Elmer Avenue

15

Filed

G. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1928, to April 25, 1928.

that I last saw him alive on April 25, 1928,

and that death occurred, on the date stated above, at 7:50 A.M.

The CAUSE OF DEATH\* was as follows:

Paralysis of Diaphragm resulting from vascular thrombosis.

(duration) 2 yrs. about mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) L. J. Martin

M. D.

/25, 1928 (Address) 1201 N. Calvert Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Gordon Park Burial Ground

ADDRESS

1003 W. Baltimore St

E 33289

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33289

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1808 Ramsay* ST., *19-28* WARD)2-FULL NAME *John Melvin Sharp*(a) RESIDENCE No. *1808 Ramsay*  
(Usual place of abode)Length of residence in city or town where death occurred *1* yrs. *6* mos. *14* ds.

ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male**white**single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct. 21-1926*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*1**6**4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*not any job*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*

10 NAME OF FATHER

*Ernest C Sharp*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Queen Anne - Md*

12 MAIDEN NAME OF MOTHER

*Willa M Bowen*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Farmers Md*

PARENTS

14 Informant  
(Address)*Willa M Sharp  
2828 Ramsay St*

15

Filed

*6 MAY 1928*  
*APW* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 25* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from *March 4*, 19*28*, to *April 25*, 19*28*, that I last saw him alive on *April 24*, 19*28*, and that death occurred, on the date stated above, at *8:40 A* m.  
The CAUSE OF DEATH\* was as follows:*Sarcoma right kidney*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

*Physical*

(Signed)

*4/25/28*

(Address)

*301 East ...*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

*Woodlawn Cemetery**Apr. 27 1928*

ADDRESS

*1003 W.**Baltimore*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33290

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. C 704 E. Ball St., 27-43 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 6605 Seylon Ave. St. 27-43 Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. E 33290

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 Color or Race

white

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

4/3/1909

## 7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

181123

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Auto driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

OK to land 1

## 10 NAME OF FATHER

Alvin P. Fletcher

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

St. Michigan

## 12 MAIDEN NAME OF MOTHER

Anna Duffy

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Kansas

## 14

Informant (Address)

Alvin P. Fletcher  
6605 Seylon Ave.

## 15

Filed

G. HANSON Jan 11 1928  
OK Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr. 25 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Lynd poisoning  
suicide

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed W. J. Ray M. D.

26. 19 28 (Address)

1639 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

National Cemetery

Date of Burial

4/27 1928

## 20 UNDERTAKER

J. J. Fakes & Sons

ADDRESS

1318 Light

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33291

## CERTIFICATE OF DEATH

E 33291

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *3503 Hayward* ST. *27-55* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME *Ebenezer Thomson*(a) RESIDENCE NO. *3503 Hayward* ST.,

## WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S., if foreign birth? *48* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*a If married, widowed, or divorced  
HUSBAND of *Martha A. Thomas*  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *July 5/1854*AGE Years *73* Months *9* Day *21* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Cloth Manufacturer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Retired*BIRTHPLACE (city or town) (State or country) *Scotland*10 NAME OF FATHER *John Thomson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Scotland*12 MAIDEN NAME OF MOTHER *Mary Cornish*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Scotland*Informant *Martha A. Thomson*(Address) *3503 Hayward St. Baltimore, Md.*Filed *6-19-28* 19 *28* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26-1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 15*, 19*28*, to *April 26*, 19*28*.that I last saw him alive on *April 26*, 19*28*.and that death occurred, on the date stated above, at *4:10* a.m.

The CAUSE OF DEATH\* was as follows:

*Uræmia*(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *15* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *Charles J. Wells* M. D., 19 (Address) *5274 Park Heights Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Ashbury Cemetery* *April 29, 1928*

20 UNDERTAKER

ADDRESS

*Harry W. Chlen* *1944 W North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33292

## CERTIFICATE OF DEATH.

31 E 33292

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 2.4.1 WARD 35)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John DockinsHAUBERT(a) RESIDENCE No. 1407 Deer st,

(Usual place of abode)

ST., Unknown WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced

HUSBAND of  
or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1899

April 12

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

29

0

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Maryland

10 NAME OF FATHER

Unknown Peter Dockins

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Austria

12 MAIDEN NAME OF MOTHER

Unknown Rose

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Austria

4

Informant  
(Address)

Hospital Records

5

Filed

1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 10, 1928 to April 24, 1928that I last saw him alive on April 24, 1928and that death occurred, on the date stated above, at 7.10 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) Unknown yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis Clinical & lab.(Signed) L. J. Mudd M. D.4-24-28 (Address) Baltimore City Hospitals\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Holy Cross A.C.B.Apr. 27-28

20 UNDERTAKER

ADDRESS

Margaret J. Flynn 1407 Light St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33293

## CERTIFICATE OF DEATH.

31 E 33293

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Baltimore City Hospitals (T 18-76) ST., 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Mills(a) RESIDENCE No. 930 W. Saratoga st.ST., 18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Clarence Mills or) WIFE of6 DATE OF BIRTH (month, day, and year) 19077 AGE Years 21 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Sam. Harris11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky12 MAIDEN NAME OF MOTHER Ida Lane13 BIRTHPLACE OF MOTHER (city or town) (State or country) MarylandInformant Hospital Records (Address)Filed 1928 APR 29 JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 192817 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 19 28, to April 25, 19 28.that I last saw her alive on April 25, 19 28.and that death occurred, on the date stated above, at 6.20 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) Unknown yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Clinical and autopsy(Signed) L. M. Madder M. D.4-26-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Mr. AuburnApr 28, 28

## 20 UNDERTAKER

1027  
Wood HillJohn H. Toadwin



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)2-FULL NAME Asbury Wilson(a) RESIDENCE No. 1577 W. Franklin(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos.ST. 1927 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleColoredMarried5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofEstelle

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.59

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Funeral Director

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town)  
(State or country)Md

9 NAME OF FATHER

Arthur Wilson10 BIRTHPLACE OF FATHER (city or town)  
(State or country)Md

11 MAIDEN NAME OF MOTHER

Jane Wilson12 BIRTHPLACE OF MOTHER (city or town)  
(State or country)MdInformant Beards

(Address)

JOHNS HOPKINS HOSPITAL

Filed

27 19281928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1928

17

I HEREBY CERTIFY, That I attended deceased from  
March 17, 1928, to April 26, 1928,  
that I last saw him alive on April 26, 1928,  
and that death occurred, on the date stated above, at  
The CAUSE OF DEATH\* was as follows:Carcinoma of Stomach  
& metastases to liverCONTRIBUTORY  
(Secondary)

(duration)

6 mos. to 1 yr  
yrs. mos. ds.Gastric Hemorrhage  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? yes Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Autopsy

(Signed)

S. E. Stewart, M. D.  
4/26, 1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

Mt. Auburn

20 UNDERTAKER

John T. ...

DATE OF BURIAL

Apr 28, 1928

ADDRESS

1027  
Round Hill

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33295

## CERTIFICATE OF DEATH

90 E 33295

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *#5 Highfield E. ST.* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

*Adam C. Nowemaker*

## (a) RESIDENCE NO.

*#5 Highfield Rd. E. ST.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *9* yrs. *—* mos. *—* ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced, (write the word) <i>Widowed</i>
--------------------	---------------------------------	---

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Marj A. Nowemaker*

DATE OF BIRTH (month, day, and year)

*March 26, 1842*

AGE

*86* Years

Months

*1*

Days

*0*If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Retired*BIRTHPLACE (city or town)  
(State or country)*New Freedom Pa.*

## 10 NAME OF FATHER

*Jacob Nowemaker*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Penna.*

## 12 MAIDEN NAME OF MOTHER

*Sydia A. Gehart*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Penna.*

Informant

(Address)

*John P. Lamber  
5 E. Highfield Road*

Filed

*1928 C. M. JONES, R.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26/28*

17

I HEREBY CERTIFY That I attended deceased from

*April 17, 1928, to April 26, 1928*that I last saw him alive on *April 26, 1928*and that death occurred, on the date stated above, at *12:30 P.m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*(duration) *Unknown* yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) *50* yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical Examination*(Signed) *E. J. Jones* M. D.4261928 (Address) *4936 Park Heights Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Freedom Pa April 29 1928*

20 UNDERTAKER

ADDRESS

*Chas E. Jones 802 Madison Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33296

## CERTIFICATE OF DEATH.

38 E 33296

1-PLACE OF DEATH *Balto City Hospt.*CITY OF BALTIMORE: (No. *Balto Md* ST. *18-76* WARD)2-FULL NAME *Andrew Morgan*(a) RESIDENCE NO. *932 W. Fayette St.*

(Usual place of abode)

Length of residence in city or town where death occurred *7* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced (write the word) *Separated*

5a If married, widowed, or divorced HUSBAND of or WIFE of

DATE OF BIRTH (month, day, and year) *1885*AGE *43* Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Painter*BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *unknown*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *unknown*Informant *Balto City Hospt* (Address) *Balto Md*Filed *1928* Registrar *R. J. K.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-24 1928*17 I HEREBY CERTIFY, That I attended deceased from *4-4-1928* to *4-24-1928* that I last saw him alive on *4-23-1928* and that death occurred, on the date stated above, at *12.35 A. m.*

The CAUSE OF DEATH\* was as follows:

*Terminal*  
*Broncho pneumonia*  
*General Paralysis of Insane*CONTRIBUTOR *Septic Infection* (duration) yrs. mos. ds.

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical & Serological*(Signed) *Harry H. Brown* M. D.19 (Address) *Baltimore City Hospt*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
*MOVIAL*

DATE OF BURIAL

*Town Neck Cem* *4/27 1928*20 UNDERTAKER *Daniel Easton* ADDRESS *916**Og rd*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33297

## CERTIFICATE OF DEATH.

E 33297

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *619 Rosedale* — ST. *16-67* WARD)

## 2-FULL NAME

*Mary Pearl Linlayson*

## (a) RESIDENCE NO.

*619 Rosedale*

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

*40* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*married*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*W. S. Linlayson*

## 6 DATE OF BIRTH (month, day, and year)

*June 23-1883*

## 7 AGE

Years

*44*

Months

*10*

Days

*2*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

*House wife*

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Va*

## 10 NAME OF FATHER

*Mrs. W. Brant*

## 11 BIRTHPLACE OF FATHER (city or town)

*Va*

(State or country)

## 12 MAIDEN NAME OF MOTHER

*Sarah J. Shipley*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Va*

(State or country)

## Informant (Address)

*W. S. Linlayson  
619 Rosedale St*

## Filed

*C. MARZON JONES, M. D.  
Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 25 1928*

17

I HEREBY CERTIFY, That I attended deceased from *July*, 1916, to *April 25*, 1928, that I last saw her alive on *April 25*, 1928, and that death occurred, on the date stated above, at *3 30 p* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage**4 hrs.*

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

*Hypertension*

(duration)

*12* yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical Diagnosis*

(Signed)

*J. W. Keown*

M. D.

(Address) *1938 Linden Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Woodlawn Cem*

## DATE OF BURIAL

*Apr 28 1928*

## 20 UNDERTAKER

*J. J. Jones*

## ADDRESS

*714 Ave*



E 33298 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33298

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *619 McCabe Ave* ST. *27-48* WARD)2. FULL NAME *Harry George Brooks*(a) RESIDENCE NO. *619 McCabe Ave* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *48* yrs. *9* mos. *13* ds.

Now long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *white*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) *July 12 - 1879*

AGE

Years *48*Months *9*Days *13*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Street Salesman*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Baltimore Maryland*10 NAME OF FATHER *Geo. H. Brooks*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto. Maryland*12 MAIDEN NAME OF MOTHER *Mary E. Finnigan*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto. Maryland*Informant *Miss Mary Brooks* (Address) *619 McCabe Ave*Filed *1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 25 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar. 17*, 19 *28*, to *Apr 25*, 19 *28*.that I last saw him alive on *Apr 24*, 19 *28*.and that death occurred, on the date stated above, at *3:54* m.

The CAUSE OF DEATH\* was as follows:

*Acute Bronchitis*CONTRIBUTORY (Secondary) *Chr. Myocarditis* (duration) yrs. *1* mos. *14* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Typical Examination*(Signed) *Paul D. Brown*, M. D.*Apr 25 1928* (Address) *1837 Fume. Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS *311 Spalding Ave*

E 33299 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33299

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2434 Reisterstown Road 54 WARD

## 2-FULL NAME

Solomon Goldberg

(a) RESIDENCE NO.

2434 Reisterstown Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

50 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced, HUSBAND of or WIFE of

Beber Goldberg

6 DATE OF BIRTH (month, day, and year)

Feb 26-1866

7 AGE

Years

Months

Days

62

2

—

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Fishe Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Bailey Esther

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Beber Goldberg 2434 Reisterstown Road

15

Filed

R 27 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/26 1928

17

I HEREBY CERTIFY, That I attended deceased from

Sept 10, 1927, to Apr 26, 1928.

that I last saw him alive on Apr 26, 1928.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Ch myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral embolus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Physical

(Signed) A. C. H. Mattern, M. D.

4/27/1928 (Address) 733 Avenue 11

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hebrew Cemetery

4/27 1928

20 UNDERTAKER

ADDRESS

Jack Lewis 1439

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33300

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

E 33300

REGISTERED NO.

CITY OF BALTIMORE: (NO. *45* *27-56* ST. *5* WARD)

2-FULL NAME

*Harry Cohen*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *5302* *Incunating Ave.* ST. *5* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 1928*7 AGE *43* Years Months Days If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Tailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Russia*10 NAME OF FATHER *Sait Cohen*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Cohen*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*14 Informant *Jack Lewis* (Address) *1439 E. 5th St.*15 Filed *1928* *10/11* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26 1928*

17

I HEREBY CERTIFY, That I attended deceased from *2-6-28*, 19 *28*, to *April 26*, 19 *28*, that I last saw him alive on *April 26*, 19 *28*, and that death occurred, on the date stated above, at *9:15 P.* in The CAUSE OF DEATH\* was as follows:*Carcinoma of rectum & sigmoid colon*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) *1* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *Feb. 9, 1928*Was there an autopsy? *no*

What test confirmed diagnosis

*Microscopic*  
*Augustine J. Von Schuyler, D.*  
*St. Agnes Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Hebrew Burial* *4/28 1928*

20 UNDERTAKER

ADDRESS

*Jack Lewis* *1439 E. 5th St.*

33301

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3901 Park Heights Ave.* ST. *15-58* WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

*10* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M.*

4 COLOR OR RACE

*W.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widow.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Mary E. Payne Maddox*

6 DATE OF BIRTH (month, day, and year)

*Mar 7, 1843*

7 AGE

Years

Months

Days

*84**5**19*

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Prince William Co Va*

10 NAME OF FATHER

*Robert T. Maddox*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Va*

12 MAIDEN NAME OF MOTHER

*Phidacum Reid*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Stafford Co Va*

14

Informant (Address)

*Mrs Marion P. King 3901 Park Heights Ave*

15

Filed

*27 1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 26, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*April 19, 1928 to April 26, 1928.*that I last saw him alive on *April 25, 1928.*and that death occurred, on the date stated above, at *10 A.M.*

The CAUSE OF DEATH\* was as follows:

*Uremic Coma  
Chronic interstitial nephritis*(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

*General arteriosclerosis*(duration) *10* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *James S. Ashhurst*, M. D.(Address) *4012 Park Heights Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR DE-NOVAL

DATE OF BURIAL

*Warrington & Daugherty Co Va**Apr 28, 1928*

20 UNDERTAKER

*Centerville Va**1725 N. Gay St. Balt.*



E 33302

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3108 Bell Ave. ST. 17-50 WARD)REGISTERED NO. 90 E 33302  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2-FULL NAME Doctor Gustavus Bruce Hedges(a) RESIDENCE NO. 3108 Albee St  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST. WARD

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Caroline R  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Oct 10 18567 AGE Years 71 Months 6 Days 26 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumbehead Ind10 NAME OF FATHER Deatur Hedges11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va12 MAIDEN NAME OF MOTHER Mary Beale13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind14 Informant R. M. Long  
(Address) 3425 Wm. Place15 Filed 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 192817 I HEREBY CERTIFY, That I attended deceased on  
April 26, 1928, tothat I last saw him alive on April 26, 1928  
and that death occurred, on the date stated above, at 430 A. m.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency.  
Myocardial disease.

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Hypertension (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Usual symptoms.(Signed) James H. Hannon M. D.  
19 (Address) 9 E. Chase St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
Wm. C. Hannon DATE OF BURIAL 4/27/28UNDERTAKER Wm. C. Hannon ADDRESS 502 E North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33303

## CERTIFICATE OF DEATH.

\* 66 E 33303

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital - 4 St., 2 Ward)2-FULL NAME Reynolds Carlisle(a) RESIDENCE NO. German town Md. - 800 St., 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 Color or Race White5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bella Carlisle6 DATE OF BIRTH (month, day, and year) March 15, 1890

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min. 38 1 12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chesapeake

(State or country)

10 NAME OF FATHER James Carlisle11 BIRTHPLACE OF FATHER (city or town) Chesapeake

(State or country)

12 MAIDEN NAME OF MOTHER Mary Cooper13 BIRTHPLACE OF MOTHER (city or town) Chesapeake

(State or country)

14

Informant (Address) Olafson Carlisle15 Filed 1928

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows: Alcoholism

(duration) yrs. mos. ds.

## CONTRIBUTORY

Secondary

(duration) yrs. mos. ds.

(Signed) W. J. Mc

(Coroner) M. D.

Address 1030 S. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKEN

ADDRESS

Berryville Va  
Wm Cook4/27 1928  
For E. W. Cook

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33304

## CERTIFICATE OF DEATH.

E 33304

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Woman's Hospital 6-10* WARD)2-FULL NAME *Mrs. Tillie Coyne*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *425 - N. Patterson Park* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Edward Coyne*6 DATE OF BIRTH (month, day, and year) *July 21, 1875*7 AGE Years *52* Months *9* Days *5* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House work.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Kent County, Md.* (State or country)10 NAME OF FATHER *Ferdinand Sykes*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Wilhelmina Lemke*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Martha Crow* (Address) *Edgewood Avenue*15 Filed *1926* *19* *11:30* *JAMES M. H.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 24*, 19*28*, to *April 26*, 19*28*, that I last saw her alive on *April 26*, 19*28*, and that death occurred, on the date stated above, at *2:45 A. m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma, right breast. Metastases to brain. (Radical amputation rt. breast 3 years ago)*(duration) *3* yrs. mos. ds.CONTRIBUTORY *Toxemia* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*What test confirmed diagnosis? *-*(Signed) *A. H. Krook*, M. D., 19 (Address) *Woman's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Betterton Rd**4/27 1928*

UNDERTAKER

ADDRESS

*Wm Cook**502 E. North*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33305

## CERTIFICATE OF DEATH

E 33305

## 1-PLACE OF DEATH

City of BALTIMORE (No. 738. S Light St Ward 9-2-30)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada B. Hooper(a) RESIDENCE NO. 738 Light St

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofWm H. Hooper

6 DATE OF BIRTH (month, day, and year)

Sept 1 - 1856

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min..

71 8 26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balt Md10 NAME OF FATHER Wm Kirby

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Balt Md12 MAIDEN NAME OF MOTHER M. Shooter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balt Md

14

Informant

(Address)

Wm H. Hooper  
738. S Light St

15 Filed

19

MISS JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

April 26/28

17

I HEREBY CERTIFY, That I attended deceased from

March 29/28to April 26/28

19

that I last saw her alive on April 26/28

19

and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH\* was as follows:

Paralysis, (Cerebral)

CONTRIBUTORY

(Secondary)

5 weeks  
after stroke of the brain

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Dr. H. B. Holt M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Cedar HillApril 30 1928

20 UNDERTAKER

ADDRESS

Geo M. Smith811 N. Wolfe



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33306

## CERTIFICATE OF DEATH.

REGISTERED NO. 101-001  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 N. Castle ST., 7-13 WARD)2-FULL NAME Elmore B. Schultz(a) RESIDENCE No. 909 N. Castle

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 19 1926

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

1

5

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md.

10 NAME OF FATHER

Geo Schultz

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Cath Rosenberger

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore

14

Informant  
(Address)Cath Rosenberger  
200 N. Calver St.

15

Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1928

17

I HEREBY CERTIFY, That, attended deceased from  
April 18, 1928, to April 24, 1928.  
 that I last saw him alive on April 24, 1928,  
 and that death occurred on the date stated above, at 6:30 p.m.  
 The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
 (duration) yrs. mos. 6 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Holy Redeem

Geo M. Smith &amp; Son

April 24 1928

811 New York

E 33307

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33307

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1421 Madison Ave Ward 14-70)2-FULL NAME William Lewis Scott(a) RESIDENCE NO. 1421 Madison Ave Ward 14-70(Usual place of abode)  
Length of residence in city or town where death occurred 34 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Kate Scott6 DATE OF BIRTH (month, day, and year)  
Dec. 31, 18747 AGE Years Months Days  
53 3 25 26.  
IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pullman Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O.

## 9 BIRTHPLACE (city or town)

(State or country) Seetherville, Md10 NAME OF FATHER John Scott11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Md.12 MAIDEN NAME OF MOTHER Katie ?13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Md.14 Informant Katie Scott  
(Address) 1421 Madison Ave15 Filed 1928 C. H. Jones Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 192817 I HEREBY CERTIFY, That I attended deceased from April 19, 1928 to April 26, 1928, that I last saw him alive on April 25, 1928, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis  
(duration) 4 yrs. mos. ds.  
CONTRIBUTORY Cardiac Hypertrophy  
(Secondary)  
(duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of \_\_\_\_\_

Was there an autopsy?

What test confirmed diagnosis? St. M. East4/27/28 (Signed) 2005 St. M. East  
(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Auburn Cemetery Date of Burial April 29, 1928

20 UNDERTAKER

Mrs. Katie R Williams & Schroeder ADDRESS 322

E 33308

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33308

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 E Fayette

ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. A. Fitzgerald

(a) RESIDENCE NO. 1639 E Fayette

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

3

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 24 1927

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti Md.

10 NAME OF FATHER

Wm Fitzgerald

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Charlotte Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Charlotte Fitzgerald 1639 E Fayette st

15

Filed

27 1928

HAYDON HONOLULU H. E. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 1928, to April 27 1928.

that I last saw him alive on April 20 1928

and that death occurred, on the date stated above, at 2<sup>20</sup> A.m.

The CAUSE OF DEATH\* was as follows:

Tubercular Meningitis (secondary)

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Pneumonia (Feb 1928) (etio Media)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical

(Signed)

4/27/28

(Address)

R. J. Young M. D. 429 Monument st

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

arbury cemetery

DATE OF BURIAL

April 28 1928

20 UNDERTAKER

Edward Bryan Orleans st

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33309

## CERTIFICATE OF DEATH.

182 E 33309

## 1-PLACE OF DEATH

City of BALTIMORE

Harbor foot of Chute St., 13-50 (Ward)

## 2-FULL NAME

John Jeworowicz

## (a) RESIDENCE NO.

3235 Elliott St.

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 7 mos. 8 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

September 15-1919.

## 7 AGE

Years

Months

Days

10

IF LESS than  
1 day.....hrs.  
or.....min.

8

7

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....School boy(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town).....Baltimore.

(State or country)

MD.

## 10 NAME OF FATHER

Ludwig Jeworowicz.

## 11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Poland,

## 12 MAIDEN NAME OF MOTHER

Antonina Blazyz,

## 13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Poland,

## 14

Informant.....Ludwig Jeworowicz.

(Address).....3235 Elliott Street

## 15 Filed.....19

G. H. W. K. Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year).....1925

## 17

I HEREBY CERTIFY that I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-  
topsy or inquiry.) find that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH is as follows:

CONTRIBUTORY  
(Secondary)

(Signed).....

(Address).....

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

St. Stanislaus, April 25, 1928.

## 20 UNDERTAKER

ADDRESS

M. J. Sadowski, 705 S. Lombard



E 33310

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 33310

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore City Hospital*)ST. *5th* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST. *Jefferson* WARD

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/21* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from *4/16*, 19*28*, to *4/21*, 19*28*.that I last saw *he* alive on *4/21*, 19*28*, and that death occurred, on the date stated above, at *3:35 A.M.*

The CAUSE OF DEATH\* was as follows:

*Old myocardial  
infarction  
due to  
arteriosclerosis  
(duration) yrs. mos. ds.*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physician's*  
(Signed) *R. M. Welch*, M. D.  
, 19 (Address) *Baltimore City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*Asbury cemetery April 27 1928  
Edward Bryson orleans st*

E 33311

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33311

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 N. Mount ST. 19-27 WARD) ✓

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah A. Prann(a) RESIDENCE NO. 207 N. Mount  
(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred none mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofno6 DATE OF BIRTH (month, day, and year) August 9, 18547 AGE 73 Years Months 8 Days 15 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chestertown Md.  
(State or country)10 NAME OF FATHER Thomas Smith11 BIRTHPLACE OF FATHER (city or town) Chestertown  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Sarah Smith13 BIRTHPLACE OF MOTHER (city or town) Kent Island  
(State or country) Maryland14 Informant Anna Colwell  
(Address) 207 N. Mount St.15 Filed 1928 19 19 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 19 2817 I HEREBY CERTIFY, That I attended deceased from 4/11 19 24 to 4/25 19 28  
that I last saw her alive on 4/24 19 28and that death occurred, on the date stated above, at 4/20 m.

The CAUSE OF DEATH\* was as follows:

Myocardial infarct.CONTRIBUTORY (Secondary) Ch. heart disease (duration) yrs. 6 mos. 7 ds.18 Where was disease contracted if not at place of death? at place of deathDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? physical exam  
(Signed) W. J. Jackson M. D.19 (Address) 10 E. W. Smith St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

West Auburn Cemetery 4/27 19 2820 UNDERTAKER Mrs.ADDRESS 322Harold R. Williams H. Schenck

E 33312

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33312

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital

St., 26-39 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace A. Tabeling

(a) RESIDENCE NO. 3308 E. Baltimore

(Usual place of abode)

St. Ward

Length of residence in city or town where death occurred

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)  
Married

F

W

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Joseph H Tabeling

6 DATE OF BIRTH (month, day, and year) Sep 23/1908

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

19

7

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER Chas. B. Randall

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto., Md.

12 MAIDEN NAME OF MOTHER Mary A. :uthall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto., Md.

14

Informant

Husband

(Address)

15

Filed....., 19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25<sup>1923</sup>

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said

Inquiry that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
General Peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Probable ruptured (old)

pyosalpinx

(Signed)

(Coroner)

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Oak Lawn Cem

April 28 1923

20 UNDERTAKER

J. J. Herr

150 N. Luzerne

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33313  
PLATE OF DEATH

## CERTIFICATE OF DEATH.

E 33313

City of BALTIMORE: (No. 215 N Bond St. 6-10 Ward)2-FULL NAME Foster Rita Dangle(a) RESIDENCE NO. Foster Rita Dangle(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race White5 Single, Married, Widowed, or Divorced. (write the word) single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-26-28

7 AGE

Years

Months

Days

IF LESS than  
1 day...hrs.  
or...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind

(State or country)

10 NAME OF FATHER John Earl11 BIRTHPLACE OF FATHER (city or town) Ind

(State or country)

12 MAIDEN NAME OF MOTHER May Lukas13 BIRTHPLACE OF MOTHER (city or town) Ind

(State or country)

PARENTS

14

Informant  
(Address) John Earl  
215 N Bond

15 Died

1928

Registrar K.H.H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26-28

17

I HEREBY CERTIFY, That I attended deceased from 4-26-28 to 4-26-28, that I last saw her alive on 4-26-28 and that death occurred, on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH was as follows:

Ischaemic heart disease,  
hypertension,

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death? UnknownDid an operation precede death? No

Date of

Was there an autopsy? NoWhat test confirmed diagnosis? Toxicology(Address) 600 N. BondM. D. W.H.H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Oak Lawn Cem. April 27 1928  
For. J. Herr 156 N. Luzerne ave.



E 33314

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33314

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital

St. 3rd Ward)

2-FULL NAME Solomon Krout

(a) RESIDENCE NO. 109 S. Spring St

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.

mos.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 20 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)

Male

white

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 1839

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

88

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work. Feather(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Merchant (retired)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant Sinai Hospital Records  
(Address)

15

Filed

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Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 27/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry find that said deceased came to his death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia (Terminal)  
(Accidentally fell over chair-fracture  
of neck left femur. 2 weeks ago) ds.

CONTRIBUTORY

(Secondary)

(Signed)

(Coroner)

mos.

ds.

M. D.

4/27/28 (Address)

500 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds.

In the

State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL

20 UNDERTAKER

1928

1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33315

## CERTIFICATE OF DEATH.

E 33315

1-PLACE OF DEATH *At home. Woodlawn - Baltimore Md.* REGISTERED NO. *90*  
 CITY OF BALTIMORE: (No. *Windsor Mill Road near Grant Ave.* ST. *28* WARD *65*)  
 2-FULL NAME *Bettel Armour Simmons*  
 (a) RESIDENCE NO. *Windsor Mill Rd. Woodlawn. Md.* ST. *28* WARD *65*  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred *18* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Martha M. Simmons*

6 DATE OF BIRTH (month, day, and year) *June 26, 1896*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*31 9 29*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Police*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *B. & O. R. R.*

9 BIRTHPLACE (city or town) *Lansel, Md.* (State or country)

10 NAME OF FATHER *Joseph B. Simmons*

11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)

12 MAIDEN NAME OF MOTHER *Clara Galvin*

13 BIRTHPLACE OF MOTHER (city or town) *Lansel, Md.* (State or country)

14 Informant *Mrs. Martha M. Simmons* (Address) *Windsor Mill Rd.*

15 Filed *27 1928* C. 19 *R. M. L.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 25 1928*

17 I HEREBY CERTIFY, That I attended deceased from *7:45* to *Apr 25*, 1928, that I last saw him alive on *Apr 23*, 1928, and that death occurred, on the date stated above, at *5:45 p.m.*

The CAUSE OF DEATH\* was as follows:

*La Grippe - Myocarditis - Coronary Thrombosis.*

(duration) yrs. *3* mos. ds.

CONTRIBUTORY *Cardiac Failure.* (Secondary) *sudden*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical.*

(Signed) *Clement R. Morrow*, M. D.

, 19 (Address) *Hillsdale.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Lorraine Park Cemetery April 28 1928*

20 UNDERTAKER

ADDRESS

*John A. Henry 715 Light St*

33316

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33316

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 Furrow ST. W. H. M. G. WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 213 Furrow

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 9 mos. 17 ds.ST. W. H. M. G. WARD(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO. 1897

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Anna P. Kennedy6 DATE OF BIRTH (month, day, and year) July 17 1897

7 AGE

Years

Months

Days

If LESS than 1 day... hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker(b) General nature of industry, business, or establishment in which employed (or employer) Kennedy Iron(c) Name of employer Kennedy9 BIRTHPLACE (city or town) (State or country) St. Louis, Mo.10 NAME OF FATHER John P. Kennedy11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.12 MAIDEN NAME OF MOTHER Anna P. Kennedy13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Louis, Mo.

14

Informant (Address) Anna P. Kennedy  
4117 Baltimore St.

15

Filed 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 1928

17

I HEREBY CERTIFY, That I attended deceased from April 21 1928, to April 24 1928.that I last saw him alive on April 24 1928, and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH\* was as follows:

Bronchitis-Pneumonia - uncomplicated(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓Did an operation precede death? ✓ Date of ✓Was there an autopsy? noneWhat test confirmed diagnosis? Clinical(Signed) E. Wells Kennedy M. D.  
4/27 1928 (Address) 2000 Hallen St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOTAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Eastern Cemetery April 28 1928  
W. H. M. G. 1852 N. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33317

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 2809 N. Calto

2. FULL NAME

Kenneth J. Welser

(a) RESIDENCE NO.

2809 N. Calto

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 4 mos. 4 ds.

ST. 20th WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

Filed

19

Registrar

ST. 20th WARD

How long in U. S., if of foreign birth?

(If non-resident give city or town and State) yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from Apr 26, 1928, to Apr 26, 1928, that I last saw him alive on Apr 26/28

And that death occurred, on the date stated above, at 12:40 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Edema, Acute  
Coronary Arteriosclerosis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Howard J. Jones

(Address)

7077 8th St

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

UNDERTAKER

ADDRESS

Western Cemetery April 27, 1928  
1850 N. Calto St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33318

## CERTIFICATE OF DEATH.

90 E 33318

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1418 N Pratt* St., *14-28* Ward)

Registered No. ....

## 2-FULL NAME

*Cooper J Albers*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *1418 N Pratt*

St.,

Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

*Male*

4-COLOR OR RACE,

*White*5-Single  
Married  
Widowed,  
or Divorced,  
(Write the word.) *Married*5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of*Eliz. Albers*

6-DATE OF BIRTH (month, day and year)

*Sept 14 1845*

7-AGE

*82 7 10*

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work.....(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town),  
(State or Country),*Germany*10-NAME OF  
FATHER,*Wm. Albers*11-BIRTHPLACE  
OF FATHER (city or town),  
(State or Country),*Germany*12-MAIDEN NAME  
OF MOTHER,*not known*13-BIRTHPLACE  
OF MOTHER (city or town),  
(State or Country),*Germany*

14-

(Informant)

(Address)

*Elizabeth Albers**1418 N Pratt St*

15-

Filed

1921

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). *4-24-1928*I HEREBY CERTIFY, That I attended deceased from  
*Feb 22* 19*27*, to *Apr 24* 19*28*.that I last saw him alive on *Apr 24* 19*28*.and that death occurred, on the date stated above, at *130 P* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Myo-  
carditis*

CONTRIBUTORY

(Secondary)

(Duration) *2* yrs. .... mos. .... ds.18-Where was disease contracted  
If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*4/27 1928*

(Address)

*1729 N Pratt St*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL,

*Holy Redeemers**4-28, 1928*

20-UNDERTAKER,

ADDRESS

*E & B Harbo 115 E Pratt St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33319

## CERTIFICATE OF DEATH.

E 33319

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

3048 Brighton

St. 16-67 Ward)

## 2-FULL NAME

Richard H. M. Koimer

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No.

3048 Brighton

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

10 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

SEX. Male	4-COLOR OF RACE. White	5-Single, Married, Widowed, or Divorced. (Write the word.) Single
--------------	---------------------------	---

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

Oct 23 1904

7-AGE

23 yrs. 6 mos. 3 ds.

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Teller

(b) General nature of industry, business, or establishment in which employed (or employer)

Baltimore Trust Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country)

Mo

10-NAME OF FATHER

D. Millers Koimer

11-BIRTHPLACE OF FATHER (city or town) (State or Country)

Va.

12-MAIDEN NAME OF MOTHER

Tabitha Sommer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

Germany

14-

(Informant)

Sarah C. Sommer

(Address)

3048 Brighton St.

15-

Filed

APR 27 1928

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-25-1928

17- I HEREBY CERTIFY, That I attended deceased from

19 to April 25 1928

that I last saw him alive on April 25 1928

and that death occurred, on the date stated above, at 530 P.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sarcosine San

(Signed) Dr. D. P. Jones M. D.

APR 26, 1928 (Address) Med. Assn. Bldg.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL

Removal to Wayneboro Va.

4-28 1928

20-UNDERTAKER

ADDRESS

Mrs. Charles G. Rohde 2327 Edmondson Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33320

E 33320

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1221 Cleaveland

Registered No.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nolte

(a) Residence No. 1221 Cleaveland

(Usual place of abode)

St.

Ward.

Length of residence in city or town where death occurred

yrs.

mos.

2 mos.

Now long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-Single,

Married,

Widowed,

or Divorced,

(Write the word.)

Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 4-26-28

7-AGE.

0 yrs. 0 mos. 0 ds.

If LESS than 1 day.

3 hrs. or... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balt. Md.

10-NAME OF FATHER,

Chas. Nolte

11-BIRTHPLACE

OF FATHER (city or town, State or Country), Germany

12-MAIDEN NAME OF MOTHER,

Margt. Belle

13-BIRTHPLACE

OF MOTHER (city or town, State or Country), Germany

11- (Informant) Chas. Nolte

(Address) 1221 Cleaveland St.

13-

Filed.

27 1928

C. H. JONES, JR.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-26-28

17- I HEREBY CERTIFY, That I attended deceased from April 26, 1928, to April 26, 1928.

that I last saw him alive on April 26, 1928.

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed) Dan Campbell, M. D.

4/27, 1928 (Address) 517 E. 1st St.

\*State the Disease Causing Death (or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL,

St. Michaels Cemetery

4-27, 1928

20-UNDERTAKER,

ADDRESS

Mrs. Chas. G. Roberts

1221 Cleaveland St.

CVR

33321

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33321

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Carewell ST., 9th WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Waggoner(a) RESIDENCE NO. 1635 Carewell

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred lifetime mos.How long in U. S., if of foreign birth? lifetime mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow6 DATE OF BIRTH (month, day, and year) Oct 6<sup>th</sup> 18467 AGE 82 Years Months 6 Days 19 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) House

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)10 NAME OF FATHER Samuel Kirby11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant Samuel Kirby (Address) 1635 Carewell St.15 Filed 27 1928 19 M. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25-192817 I HEREBY CERTIFY, That I attended deceased from April 1, 1928 to April 25, 1928, that I last saw him alive on April 25, 1928, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH\* was as follows:

old age and heart disease(duration) 3 yrs. mos. ds.CONTRIBUTORY (Secondary) old age and heart disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Kirby M. D.Apr 28 1928 (Address) 1635 Carewell St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Johnnie C. Jones 1635 Carewell St.



E 33322

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33322

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3806 Glenn Ave.,

St. 27-55 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... John D. Crawford

(Residence in Baltimore: No. 3806 Glenn Ave., St. 27-55, yrs. 60, mos. 9, ds. 0)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,  
Male4-COLOR OR RACE,  
White5-Single,  
Married,  
Widowed,  
or Divorced.  
(Write the word.)  
Married

6-DATE OF BIRTH

July 16, 1853

(Month)

(Day)

(Year)

7-AGE

74

yrs.

9

mos.

9

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work... Carpenter
- (b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE,

(State or Country) Md.

PARENTS

10-NAME OF FATHER, Samuel Crawford

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Doughtery

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John D. Crawford

(Address) 3806 Glenn Ave.

15-

Filed

7 1928

G. HANCOCK JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4

25

1928

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Morrison, M. D.

(Coroner)

1928 (Address) 9622 Belvedere

\*State the disease causing death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. John's Cemetery Westminster

DATE OF BURIAL

April 28, 1928

20-UNDERTAKER,

ADDRESS

Harry N. Witzke 1534 W. Lombard

E 33323

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33323

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home &amp; Chaperon

CITY OF BALTIMORE: (No.

Broadway &amp; Franklin Ave

ST., WARD

2-FULL NAME

Mrs Annie Mules

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2003 Wilkins Ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wilbur J. Mules

6 DATE OF BIRTH (month, day, and year)

April 29, 1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

11

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Wm. Burkmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Pellica Hanes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant

Wilbur J. Mules

(Address)

2003 Wilkins Ave

15

Filed

19

G. HARRISON JONES, Jr. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25 1928

17

I HEREBY CERTIFY, That I attended deceased from

4/11 1928 to 4/25 1928

that I last saw him alive on 4/25 1928

and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH\* was as follows:

Pleurisy with effusion left (probably from endocarditis of aorta)

(duration) yrs. 1 1/2 mos. ds.

CONTRIBUTORY (Secondary)

Myocardial failure (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) J. Frank Hewitt, M. D.

4/25, 1928 (Address) Church Home &amp; Chaperon

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cemetery

April 28, 1928

20 UNDERTAKER

Harry H. Hitzke

ADDRESS

15311 Jones

213472

E 33324

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161-001  
E 33324

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)ST. 1-1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hermstad(a) RESIDENCE NO. 312 1/2 Hillen

(Usual place of abode)

ST. City WARD City

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhite

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-25-28

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind -10 NAME OF FATHER Henry L -11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind -12 MAIDEN NAME OF MOTHER Helen13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind -14 Informant Records -  
(Address)

15

Filed

7 1928 C. HARRISON JONES, R. A. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1928 to April 27, 1928, that I last saw him alive on April 27, 1928, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH\* was as follows:

Prematurity(duration) yrs. mos. ds. 2

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at homeDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None

(Signed)

J. C. Gosford

M. D.

19

(Address)

Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislaus Apr - 28 1928

20 UNDERTAKER

ADDRESS

M. F. Sudowski 705 S. Line St

E 33325

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33325

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Ave. near* ST. *Radcliffe Ave.* WARD)2. FULL NAME *Louis E. Schaub*(a) RESIDENCE NO. *Franklin Ave. near* ST. *Radcliffe Ave.* WARD *Radcliffe*

(Usual place of abode)

Length of residence in city or town where death occurred *8* yrs. mos. ds.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 27<sup>th</sup> 1869*

7 AGE

Years *58*Months *8*Days *29*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Farmer*(b) General nature of industry, business, or establishment in which employed (or employer) *Truck Farm*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Co.* (State or country) *Maryland*10 NAME OF FATHER *Louis E. Schaub*11 BIRTHPLACE OF FATHER (city or town) *Unknown* (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Annetta Melchior*13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country) *Germany*

14

Informant *Miss Annie Schaub* (Address) *Franklin near Radcliffe Ave.*

15

Filed *1928* . 19

C. HANCOCK JONES, R. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 21*, 1928, to *April 20*, 1928, that I last saw him alive on *April 20*, 1928, and that death occurred, on the date stated above, at *5 A.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular Heart Disease*(duration) *2* yrs. mos. ds.CONTRIBUTORY *Chronic Interstitial Nephritis* (Secondary)(duration) yrs. *7* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Laboratory*(Signed) *William Beech* M. D.27, 1928 (Address) *20 E. Boston St. Balto.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Parkwood Cemetery*DATE OF BURIAL *April 29 1928*20 UNDERTAKER *Frederick L. ...*ADDRESS *Fullerton*



E 33326

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33326

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Balto. Gen.*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed,

or Divorced, (write the word)

*married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Susie Sakers*

6 DATE OF BIRTH (month, day, and year)

*July 3 - 1890*

7 AGE

*58* Years

9 Months

24 Days

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Carpenter*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Lawrence Md*

10 NAME OF FATHER

*John Thomas Sakers*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Md*

12 MAIDEN NAME OF MOTHER

*Fannie Tucker*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Maryland*

14

Informant  
(Address)*Miss Susie Sakers  
Lawrence Md*

15

Filed

19

*7-1928*  
*MAXSON JONES*  
*Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4/27/28*

17

I HEREBY CERTIFY, That I attended deceased from

*April 26, 1928, to April 27, 1928,*that I last saw him alive on *April 27, 1928,*and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia  
(Right lung)*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?*home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

*Clinical Exam.*(Signed) *Louis T. Lavy* M. D.4/27/28 (Address) *W. Balto Gen Hosp.*\*State the Disease Causing Death, or in death from Violent Causes,  
states (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Lawrence Md**4/29/28*

20 UNDERTAKER

ADDRESS

*Lloyd Lawrence* *Lawrence Md.*

E 33327

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33327

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2919 Harlem ave* ST. *16-67* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Anna G. Liberto*(a) RESIDENCE No. *2919 Harlem ave*  
(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Female White married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Joseph Liberto*6 DATE OF BIRTH (month, day, and year) *Nov 19-1907*

7 AGE

Years

Months *5*Days *7*If LESS than  
1 day, hrs.  
or min.*20*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Housework*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*10 NAME OF FATHER *Joseph Papa*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Italy*12 MAIDEN NAME OF MOTHER *Anna Alascia*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Italy*

14

Informant  
(Address)*Joseph F. Liberto  
2919 Harlem ave*

15

7 1928

*C. MARTIN JONES, M. D.  
Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 26 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*April 26*, 1928, to *April 26*, 1928.that I last saw her alive on *April 26*, 1928.and that death occurred, on the date stated above, at *7:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Heart failure due to  
chronic pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Child birth*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Joseph L. Volentini, M. D.*

27, 1928 (Address)

*18 So Broadway*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*St. Agatha's Church**April 30 1928*

20 UNDERTAKER

ADDRESS

*Robert Brookston**Calhoun  
Hollins*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33328

E 33328

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Bank St. 2-4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Peter Nadolski

(a) RESIDENCE NO. 1908 Bank St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 1856

7 AGE 71 Years Months Days If LESS than 1 day, hrs or min. 72 9 4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Zofia Nadolski (Address) 1908 Bank St.

15 Filed 19 HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from January 14, 1928, to April 27, 1928, that I last saw him alive on April 27, 1928, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Infectious arthritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P. S. &amp; S.

(Signed) John V. Sejerich, M. D.

, 19 (Address) 1738 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Holy Rosary Jan April 30 1928

20 UNDERTAKER ADDRESS

John M. Weber 401 S. Chester St

E 33329

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33329

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 166 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Camillea Owens(a) RESIDENCE NO. 712 S. Hamp ST. 166 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 7 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (c) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/18/957 AGE Years 33 Months 0 Days 0 If LESS than 1 day, 0 hrs. 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sanitation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina (State or country)10 NAME OF FATHER ?11 BIRTHPLACE OF FATHER (city or town) ? (State or country)12 MAIDEN NAME OF MOTHER Rose Owens13 BIRTHPLACE OF MOTHER (city or town) North Carolina (State or country)14 Informant Records (Address)15 Filed 8-19-28 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26/192817 I HEREBY CERTIFY, That I attended deceased from April 20, 1928 to April 26, 1928 that I last saw him alive on April 26, 1928 and that death occurred, on the date stated above, at 7:10 A. m.

The CAUSE OF DEATH\* was as follows:

Ingestion of drug(duration) 7 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) Stroke(duration) 4 yrs. 0 mos. 0 ds.18 Where was disease contracted ? if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General Sub.(Signed) C. Holmes Jones, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Calvary Cem. Apr 28, 1928

20 UNDERTAKER

ADDRESS 1027John H. Toadman 1027



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33330

## CERTIFICATE OF DEATH

101-001  
E 33330

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *4409 Wentworth Rd.* WARD *3*)2—FULL NAME *Margaret M. Bechtold*(a) RESIDENCE NO. *4409 Wentworth Rd.* WARD *3*

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds.

How long in U. S., if foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *July 15, 1865*

AGE

*62* Years*9* Months*10* Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *Timothy Kennedy*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*Informant *Margaret Flynn*(Address) *4409 Wentworth Rd.*Filed *8-19-28*C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 22-1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr 22, 1928* to *Apr 25, 1928*,that I last saw him alive on *Apr 22, 1928* and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary*(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Autopsy*(Signed) *A. C. Smith*, M. D.Address) *4409 Wentworth Rd.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Cathedral Cemetery*DATE OF BURIAL *Apr 28 1928*20 UNDERTAKER *Margaret J. Flynn*ADDRESS *1422 High St.*

E 33331

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33331

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St Joseph's Hospital*  
 CITY OF BALTIMORE: (No. *Caroline & Oliver* ST. *24-34* WARD) REGISTERED NO. *146*  
 2-FULL NAME *Mrs Nora. Ferguson* (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 (a) RESIDENCE NO. *1403. Riverside* ST. \_\_\_\_\_ WARD \_\_\_\_\_  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred *18* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced  
 HUSBAND of *William Ferguson*  
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE Years *37* Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Homemaker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*

10 NAME OF FATHER *Patrick Hughes*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*

12 MAIDEN NAME OF MOTHER *Mary Hughes*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *William Ferguson*  
*1403 Riverside*

15

Filed *1928*

*C. HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 25 19 28*

17 I HEREBY CERTIFY, That I attended deceased from *April 25*, 19 *28*, to *April 25*, 19 *28*, that I last saw her alive on *April 25*, 19 *28*, and that death occurred, on the date stated above, at *3:15 p.m.*

The CAUSE OF DEATH\* was as follows:

*Puerperal. Septicemia -*

(duration) yrs. mos. *9* ds.

CONTRIBUTORY *Cardiac dilatation*  
 (Secondary) (duration) yrs. mos. *1* ds.

18 Where was disease contracted *at home*  
 if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical*

(Signed) *A Lawrence Talbot, M. D.*

19 (Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Cathedral Cemetery Apr 28 19 28*  
*Margaret J. Flynn, + or right*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33332

## CERTIFICATE OF DEATH.

31 E 33332

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 413 Patapco Ave St. 25-75 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand Suehle(a) RESIDENCE NO. 413 Patapco Ave St. 25-75 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race Wh 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Suehle6 DATE OF BIRTH (month, day, and year) 12/29/18617 AGE 66 Years Months 3 Days 28 IF LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Export clerk W. M. Ry.(b) General nature of industry, business, or establishment in which employed (or employer) Same(c) Name of employer Western Md. Ry. Co.

## 9 BIRTHPLACE (city or town)

(State or country) Germany10 NAME OF FATHER Ferdinand Suehle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany14 Informant Wife  
(Address) 413 Patapco Ave15 Filed C. HAMPSON JONES, M. D. Registrar

1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26th 192817 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1926, to Apr 26, 1928, that I last saw him alive on March 30th, 1928, and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 1 yrs. 9 mos. 7 ds.CONTRIBUTORY (Secondary) Same(duration) 1 yrs. 9 mos. 7 ds.18 Where was disease contracted  
if not at place of death? Bellegrove 2nd avDid an operation precede death? No Date of 2/10Was there an autopsy? NoWhat test confirmed diagnosis? Examination(Signed) W. J. Harrison, M. D., 19 (Address) 303 E. Ely

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Swartz Cemetery Date of Burial 4/30/2820 UNDERTAKER George J. Dwyer ADDRESS 1735 N. 1st

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33333

## CERTIFICATE OF DEATH

E 33333

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Med Gen Hosp 8-45* St. *8* Ward)2-FULL NAME *Chas Hohl*(a) RESIDENCE NO. *1252 Clifton* St. *4* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *49* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. If of foreign birth *49* yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 Color or Race

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Barbara Hohl*

6 DATE OF BIRTH (month, day, and year)

*4/9 1859*

7 AGE

*69* Years  
*68*

Months

Days

IF LESS than  
1 day... hrs.  
or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Germany*

10 NAME OF FATHER

*John Hohl*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Mary Hohl*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant  
(Address)*Hospital Records*

15 Filed

*C. HAMISON JONES, M. D.*  
*R. H. H.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4-27-28*

19

17

I HEREBY CERTIFY, That I attended deceased from

*4-24 1928*, to *4-27 1928*that I last saw him alive on *4-27 1928*and that death occurred, on the date stated above, at *10:45 a. m.*

The CAUSE OF DEATH\* was as follows:

*Cellulitis of left forearm  
& subsequent streptococcal  
hemolytic septicaemia*(duration) yrs. mos. *21* ds.

CONTRIBUTORY

(Secondary)

*Pulmonary edema*(duration) yrs. mos. *1* ds.

18 Where was disease contracted

if not at place of death?

*Home*

Did an operation precede death?

*Yes*Date of *4-24-28*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Clinical*

(Signed)

19

*Geo. A. Thompson, M. D.*

(Address)

*105 S. Howard Ave.*

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Schwartz Cemetery**4/30 1928*

20 UNDERTAKER

ADDRESS

*George J. Ruth**1735 Harford Ave.*

Very Important See Instructions on Back of Certificates.



33334

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33334

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *507 S 12th*)ST. *26-37* WARD)2-FULL NAME *William Steve Goulas*REGISTERED NO. *100-001*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *507 S. 12th St.*

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *3* mos. *—* ds.ST. *26-37* WARD

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan. 29-27*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min. *28*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Baltimore City*10 NAME OF FATHER *Steve Goulas*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Greenville*12 MAIDEN NAME OF MOTHER *Ethel Mills*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balt.*4 Informant (Address) *Father*

5

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 27* 19*28*17 I HEREBY CERTIFY, That I attended deceased from *Baltimore*, 19*28* to *April 27*, 19*28*.that I last saw him alive on *April 27*, 19*28* and that death occurred, on the date stated above, at *11:50 A. M.*

The CAUSE OF DEATH\* was as follows:

*Acute Bronchitis Pneumonia*(duration) yrs. mos. ds. *15*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. J. Schein*

M. D.

19 (Address) *1514 Eastern Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Balto Cem.**April 28* 19*28*

20 UNDERTAKER

ADDRESS

*Geo. J. Herr 156 N. Luzerne ave.*

E 33335

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33335

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *521 W 28th*)ST. *12-51* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John T. Althoff*(a) RESIDENCE No. *521 W 28th*

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Child*6 DATE OF BIRTH (month, day, and year) *Dec 25, 1927*7 AGE Years Months Days If LESS than 1 day, hrs or min. *4 1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *md.*10 NAME OF FATHER *Lewis F. Althoff*11 BIRTHPLACE OF FATHER (city or town) (State or country) *md.*12 MAIDEN NAME OF MOTHER *Mable F. Thomas*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *md.*

14

Informant (Address) *Lewis F. Althoff 521 W 28th St*

15

Filed

8 1928

CIVIL HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26, 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 13, 1928*, to *April 26, 1928*, that I last saw him alive on *April 26, 1928* and that death occurred, on the date stated above, at *12:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Enterocolitis*(duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *DWIGHT HOTT* M. D.19 (Address) *2020 N. Charles*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Marys Hampden**April 28, 1928*

20 UNDERTAKER

ADDRESS

*Chenoweth**3615 Chestnut*

E 33336

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33336

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 W 28th St.

ST.,

WARD)

2-FULL NAME Lucy C Fair

(a) RESIDENCE NO. 415 W 28th St.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos.

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar 20, 1928, to April 26, 1928.

that I last saw him alive on April 26, 1928.

and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH\* was as follows:

Ch. Valvular Heart Disease

(duration) Several yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clin.

(Signed)

4/28/28 (Address) 2020 N. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 33837  
213

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33337

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL

ST.,

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Minnie Whitehead(a) RESIDENCE NO. Brooklyn - Md

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 14

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Single, Married, Widowed,~~  
or ~~Divorced~~. (write the word)FemaleWhiteWidow5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 11/6/69

7 AGE

59

Years

Months 5Days 21If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workHousewife(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Md

10 NAME OF FATHER

Guilla Robinson11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Md

12 MAIDEN NAME OF MOTHER

Jane Brown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Md

14

Informant  
(Address)RecordsJOHNS HOPKINS HOSPITAL

28-1928

19

C. HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 13, 1928, to April 27, 1928,  
that I last saw her alive on April 27, 1928.

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH\* was as follows:

MYOCARDIAL INSUFFICIENCY  
MITRAL INSUFFICIENCYgangrene of leg - probably due  
(?) = to arterial embolus  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)Pulmonary Embolus?  
(duration) yrs. 15 minutes18 Where was disease contracted  
if not at place of death?Home

Did an operation precede death?

XPS, Date of Apr. 20/28

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Diagnosis

(Signed)

Harold R. Bohman, M. D.

4/28/1928 (Address)

Johns Hopkins Hospital\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Edward J. SuterLowell



E 33338

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33338

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3202 Mc Elderry St.*)2-FULL NAME *Albert J. Ferries*(a) RESIDENCE NO. *3202 Mc Elderry St.*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *27* mos.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 Single, Married, Widowed,  
or Divorced, (write the word)*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*May B. Ferries.*6 DATE OF BIRTH (month, day, and year) *Aug 27, 1900*

7 AGE

Years

Months

Days

*27*If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Schoffner*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*Joseph Ferries*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Italy*

12 MAIDEN NAME OF MOTHER

*Catherine Ferries*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Italy*

14

Informant  
(Address)*Mary Palmisano  
320 W. High St*

15

Filed

*28 1928*

C. HAMPSON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26, 1928*

17

HEREBY CERTIFY, That I attended deceased from  
*April 10, 1928*, to *April 25, 1928*,  
that I last saw him alive on *April 25, 1928*,  
and that death occurred, on the date stated above, at *2.4* m.  
The CAUSE OF DEATH\* was as follows:*Chronic Nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*John A. Valentine*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*New Cathedral*

DATE OF BURIAL

*April 30*

1928

20 UNDERTAKER

*Frank V. Lepetone*

ADDRESS

*2818  
E. Palto St*

E 33339

## HEALTH DEPARTMENT—CITY OF BALTIMORE.

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*CITY OF BALTIMORE: (No. *Lombard & Greene ST.* 28-64 WARD)2-FULL NAME *August Palmisano*(a) RESIDENCE NO. *4404 Wentworth Rd.* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *40* mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. *40* mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Sarah Palmisano* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *1877*7 AGE *51* Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *M. H.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Italy*10 NAME OF FATHER *Augustine*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *Anna Sandone*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

14

Informant *J. Patti* (Address) *4014 E. Lombard st*

15

Filed *1928* *C. HAMPSON JONES, M. D.* Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 27* 192*8*

17

I HEREBY CERTIFY, That I attended deceased from *April 25*, 192*8*, to *April 27*, 192*8*, that I last saw him alive on *April 27*, 192*8*, and that death occurred, on the date stated above, at *3:45* a. m.

The CAUSE OF DEATH\* was as follows:

*Chronic Myelitis*(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical Path + exam.*(Signed) *H. R. Schmidt*, M. D.4/27, 1928 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Lorraine*

DATE OF BURIAL

*April 30*192*8*

ADDRESS

*2815 E. Balto st*

20 UNDERTAKER

*Frank V. Cipitone*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33340

90 E 33340

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Hamilton Ave ST., Roseburg WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta F. Beckman(a) RESIDENCE NO. 3704 Hamilton Ave. ST., Roseburg WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 2 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female WhiteWidowed

5a If married, widowed, or divorced, HUSBAND of or WIFE of

Maxwin Beckman

6 DATE OF BIRTH (month, day, and year)

July 4, 1904-1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7588

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hessen Germany

10 NAME OF FATHER

August Brone

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14

Informant

(Address)

Cora Hebler 3704 Hamilton Ave.

15

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1928, to April 27, 1928, that I last saw him alive on April 26, 1928, and that death occurred, on the date noted above, at 9 A.M. in.

The CAUSE OF DEATH\* was as follows:

Chronic MyocarditisPersonal history (duration) 20 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

Myocardial Infarction (duration) 30 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Sig. & Symp. hirs(Signed) Edmund Benson M. D.427 1928 (Address) Orelean

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery, April 30, 1928

20 UNDERTAKER

ADDRESS

Friedrich Lessahn & Sons Pullerton

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33341

## CERTIFICATE OF DEATH.

E 33341

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 8-12 Ward)

2-FULL NAME George J. Woodward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 2221 N. Mura St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

M W Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sept 3/1905

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

22 7 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md.

10 NAME OF FATHER Wm. Woodward

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER Mary A.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant Wm H. Woodard

(Address) 2221 N. Mura St

15

Filed 1928 G. HAMPSON JONES, Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26-1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to his death (Inquest, au-  
opsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Intracranial Hem-Fractured Skull  
Accidentally thrown from his motor-  
cycle On Biddle st bet Lakewood &  
Kenwood Aves. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

502 E. North



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33342

E 33342

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1519 E. Preston St. 5-9 Ward)

2-FULL NAME Kate M. Johnson

(a) RESIDENCE NO. 1526 Orleans St.

(Usual place of abode)

life

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 Color or Race

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Late Thos. J. Johnson

6 DATE OF BIRTH (month, day, and year)

Feb 16/1852

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

70

2

11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....

none

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

10 NAME OF FATHER Charles Pentz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto., Md.

12 MAIDEN NAME OF MOTHER Catherine Watts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto., Md.

14

Informant Margaret Crow

(Address)

1519 E. Preston St.

15

19

G. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27/28

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-topsy or inquiry.) and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chr. Myocarditis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

M. D.

4/27/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Baltimore Cemetery Apr 30/28

20 UNDERTAKER

ADDRESS

502 E North

E 33343

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 S. 12th

## 2-FULL NAME

Albert Kidwell

(Residence in Baltimore: No. 627 S. 12th

Highlandtown St.; 14 yrs., mos. da.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widowed

## 6-DATE OF BIRTH.

1894  
(Month) (Day) (Year)

## 7-AGE.

74 yrs. mos. da.

If LESS than 1 day,  
hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Carpenter

## 9-BIRTHPLACE, (State or Country),

Va.

## 10-NAME OF FATHER,

William Kidwell

## 11-BIRTHPLACE OF FATHER (State or Country),

Va.

## 12-MAIDEN NAME OF MOTHER

Bascum

## 13-BIRTHPLACE OF MOTHER (State or Country),

Va.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward D. Kidwell

(Address) 627 S. 12th St.

## 15-

Filed.

8 1928

C. HAMPSON JONES, M. D.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

April 26, 1928  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 1926, to Apr 26 1928, that I saw him alive on Apr 8 1928, and that death occurred, on the date stated above, at 2A m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis  
Mitral Regurgitation

(Duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

Arteriosclerosis

(Duration) yrs. mos. da.

(Signed) Ralph Z. Shy

Apr 26, 1928 (Address) 26 C. P. Smith St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

Mt. View

## DATE OF BURIAL.

Apr 28, 1928

## 20-UNDERTAKER

W. W. Corb

## ADDRESS

500 E. North Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33344

## CERTIFICATE OF DEATH

E 33344

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1626 N. Broadway St., 8-17 Ward)2-FULL NAME Mildred Ann Zimmerman(a) RESIDENCE NO. 1626 N. Broadway St. 8-17 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 7 ds. (If non-resident give city or town and State)  
How long in U. S. If of foreign birth? 2 yrs. 6 mos. 7 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 2 Months 6 Days 7 IF LESS than 1 day... hrs. or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)10 NAME OF FATHER John S. Zimmerman11 BIRTHPLACE OF FATHER (City or town) Baltimore, Md.  
(State or country)12 MAIDEN NAME OF MOTHER Estella M. Plank13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.  
(State or country)14 Informant M. John S. Zimmerman  
(Address) 1626 N. Broadway15 Filed C. HAMPSON JONES, M. D.  
1928 Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 192817 I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 26, 1928.that I last saw her alive on April 26, 1928.and that death occurred, on the date stated above, at 12:15 A.M.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Tuberculosis(duration) 2 yrs. 1 mo. 21 ds.CONTRIBUTORY Rickets & Anemia  
(Secondary)(duration) 2 yrs. 1 mo. 21 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? clinical(Signed) Frank J. Ayer, M. D.(Address) 2045 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery Apr. 30 1928

20 UNDERTAKER

ADDRESS

Henry H. H. H. 1501 E. Monument St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33345

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Provident Hospital*)REGISTERED NO. *33345*2-FULL NAME *Kennard Wilkins*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *1221 Jefferson St.*

(Usual place of abode)

Ward

Length of residence in city or town where death occurred *10* yrs. *10* mos. *0* ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? *10* yrs. *10* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 Color or Race

*col.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*

6 DATE OF BIRTH (month, day, and year)

*1901*

7 AGE

Years

Months

Days

*27*

IF LESS than 1 day... hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Gracerville*

10 NAME OF FATHER

*Samuel Wilkins*

11 BIRTHPLACE OF FATHER (City or town) (State or country)

*Gracerville*

12 MAIDEN NAME OF MOTHER

*Augusta Tildon*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Gracerville*

14

Informant (Address)

*Mary Cornish 1221 Jefferson St.*

15 Filed

*C. HAMPSON JONES, M.D. Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4/26/28*

17

I HEREBY CERTIFY, That I attended deceased from *4/25*, 19*28*, to *4/26*, 19*28*that I last saw him alive on *4/26*, 19*28*and that death occurred, on the date stated above, at *3:00 P.M.*

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dilatation*

CONTRIBUTORY (Secondary)

*Lobar Pneumonia*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

*Unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John W. Jones, M.D.*(Address) *Provident Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Gracerville Md.*

Date of Burial

*Apr. 28 1928*

20 UNDERTAKER

*Mrs. J. G. Locks*

ADDRESS

*1302 Jefferson*



E 33346

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33346

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Square Hosp*CITY OF BALTIMORE: (No. *Calhoun & Fayette* ST. *19-28* WARD)2-FULL NAME *Ellen Alderson*(a) RESIDENCE NO. *1414 W. Lombard* ST. *Charmersburg Va*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *10* mos.

ds. How long in U. S., if of foreign birth?

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*female*

4 COLOR OR RACE

*white*5 Single, Married, Widowed, or Divorced, (write the word)  
*widowed (?)*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *April 15 1860*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*60**11*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Factory worker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Unknown*  
(State or country)10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Unknown*14 Informant *Mrs Nora Mallett*  
(Address) *1414 W. Lombard St.*15 Filed *8 1928* For *C. HAMPSON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*April 14*, 1928, to *April 26*, 1928;  
that I last saw her alive on *April 26*, 1928,  
and that death occurred, on the date stated above, at *10:15 P.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage (left hemisphere)  
Arterio-sclerosis*(duration) yrs. mos. *8* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *E. B. Sherman*, M. D., 19 (Address) *Franklin Square Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral April 30 1928*  
20 UNDERTAKER *George Smith* Address *1532 Hollins*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33347

E 33347.

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 Brantley ST. 16-67 WARD)2-FULL NAME Mrs Jennie Eva Tydings(a) RESIDENCE NO. 745 Brantley ST. 16-67 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 0 ds.

(If non-resident give city or town and State) yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced Wife of George M. Tydings6 DATE OF BIRTH (month, day, and year) July 20, 1866

7 AGE

Years 62Months 9Days 5

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prince George Co Md.  
(State or country)10 NAME OF FATHER William Carrick11 BIRTHPLACE OF FATHER (city or town) Prince George Co Md.  
(State or country)12 MAIDEN NAME OF MOTHER Rose Foreless13 BIRTHPLACE OF MOTHER (city or town) Prince George Co Md.  
(State or country)

14

Informant (Address) Miss Rose Tydings  
745 Brantley St.

15

Filed

19

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan, 1925, to April 25, 1928.that last saw her alive on April 25, 1928.and that death occurred, on the date stated above, at 11 45 p.m.

The CAUSE OF DEATH was as follows:

Acute Cardiac Dilatation

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) 6 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Examination(Signed) R. A. Kelly, M. D., 19 (Address) 3517 E. Howard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

George L. Schmitt

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33348

101-001 E 33348

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 E. Monument ST., 7-9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virginia Elvira Hill

(a) RESIDENCE NO. 1613 E. Monument ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX <u>F</u>	4 COLOR OR RACE <u>C</u>	5 Single, Married, Widowed, or Divorced, (write the word) <u>S</u>
-------------------	-----------------------------	---

 6a If married, widowed, or divorced  
 HUSBAND of \_\_\_\_\_  
 (or) WIFE of \_\_\_\_\_
DATE OF BIRTH (month, day, and year) Dec. 26 1901

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>20</u>	<u>3</u>	<u>29</u>	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Belle  
(State or country) md.10 NAME OF FATHER Samuel Hill11 BIRTHPLACE OF FATHER (city or town) Danville  
(State or country) Va.12 MAIDEN NAME OF MOTHER Sarah Scott13 BIRTHPLACE OF MOTHER (city or town) Belle  
(State or country) md.Informant Sarah Hill (mother)  
(Address) 1613 E. MonumentFiled 8-19-28 C. HAMPSON JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1928
 17 I HEREBY CERTIFY, That I attended deceased from  
Apr. 15, 1928, to Apr. 24, 1928,  
 that I last saw him alive on Apr. 24, 1928  
 and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.  
 CONTRIBUTORY Auto myocarditis  
 (Secondary) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds.
18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Phys. Ex.(Signed) W. S. Brown M. D., 19 (Address) 1420 E. Chase

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Rebury Cem.4/29 1928

20 UNDERTAKER

ADDRESS

Byron Wright 218 McElderry St

21 3312  
E 33349

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

37-001  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

JOHNS HOPKINS HOSPITAL

ST. 5-9 WARD

## 2-FULL NAME

Anna M. Cray

(a) RESIDENCE NO.

201 W. Spry ST.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 6 mos.

How long in U. S. if of foreign birth?

(If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

5-1-28

7 AGE

Years

Months

Days

3

11

26

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

S-Car -

10 NAME OF FATHER

John

11 BIRTHPLACE OF FATHER (city or town) (State or country)

S-Car -

12 MAIDEN NAME OF MOTHER

Anna Hull

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

S-Car -

PARENTS

14

Informant (Address)

Record.

15

Filed

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1928, to April 27, 1928, that I last saw her alive on April 27, 1928, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Miliary Tuberculosis

CONTRIBUTORY (Secondary) Meningitis (tuberculous)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-Ray; Spinal Fluid

(Signed) A. C. Gagliardi M. D.

19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Asbury

DATE OF BURIAL

20 UNDERTAKER

John W. Henderson

April 29 1928  
ADDRESS 1502

E. J. Mendenhall



33350

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33350

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home Infirmary  
CITY OF BALTIMORE: (No. Broadway Fairmount ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. Joseph Casey

(a) RESIDENCE NO.

Anderson S.C. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Julia J. Casey

6 DATE OF BIRTH (month, day, and year)

May-28-1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

9

X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

architect

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self.

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

M. J. Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York

12 MAIDEN NAME OF MOTHER

Mary Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

New York

14

Informant (Address)

Julia J. Casey  
Anderson S.C.

15

Filed

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 23, 1928, to Apr 28, 1928.

that I last saw him alive on April 28, 1928.

and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH\* was as follows:

Brain tumor

Brain abscess

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 23 1928

Was there an autopsy? No

What test confirmed diagnosis? Operation  
(Signed) George B. Buel, M. D.

19 (Address) Church Home Infirmary

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Anderson S.C.

DATE OF BURIAL

Apr 27 1928

20 UNDERTAKER

Hughes &amp; Jones Inc. 1217 N. Ave.

2873  
E 33351

## HEALTH DEPARTMENT—CITY OF BALTIMORE

1001  
E 33351

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL)ST. 7-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Winifred Cordray

(a) RESIDENCE NO.

(Usual place of abode)

Aberdeen Md ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,  
or Divorced, (write the word)Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.28

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ...  
(State or country)Md -

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)Records -

15

Filed

19

1928 C. HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 6, 1928 to April 27, 1928.  
that I last saw her alive on April 27, 1928  
and that death occurred, on the date stated above, at 12:50 P.M.

The CAUSE OF DEATH\* was as follows:

Multiple AbscessesPneumonia(duration) yrs. mos. 17 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death?

YesDate of 4-12-28

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

Eugene Mills

M. D.

4-28-1928 (Address)

Johns Hopkins Hosp.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Aberdeen MdApr. 28, 1928

20 UNDERTAKER

Wm. Hickner Sons

ADDRESS

North St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33352

## CERTIFICATE OF DEATH.

57 E 33352

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1014 Brandy an St. 16-76 Ward)2-FULL NAME Cornelius Corporal(a) RESIDENCE NO. 1014 Brandy an St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 10 mos. ds.

How long in U. S. if of foreign birth?

yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male colored married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Corporal6 DATE OF BIRTH (month, day, and year) unknown 18747 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
54

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)10 NAME OF FATHER Alfred Corporal

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ada Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rosa Corporal (Address) 1014 Brandy an15 Filed C. HAMMONS JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 192817 I HEREBY CERTIFY, That I attended deceased from May 12, 1928, to Apr 25, 1928, that I last saw him alive on Apr 26, 1928, and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH\* was as follows:

Diabetes mellitus

years (duration) years mos. ds.

CONTRIBUTORY (Secondary) Diabetic gangrene of both feet, Decubitus (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of.....Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward J. Fisher, M. D.Apr 26 1928 (Address) 1612 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Laurel Cemetery Apr. 29, 28

20 UNDERTAKER ADDRESS

Mrs. R. G. Elliott 1725 Ashland

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33353

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 137 W.Ostend St.

St. Ward)

## 2-FULL NAME

Halleck Webb.

(a) RESIDENCE NO. 137 W.Ostend St.

St. Ward)

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male.

White

Widower

6a If ~~WIDOWED~~, widowed, ~~XXXXXXXX~~  
HUSBAND of  
~~XXXXXXXX~~

Elizabeth Webb.

6 DATE OF BIRTH (month, day, and year)

Do not know.

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town)

(State or country)

New Jersey.

10 NAME OF FATHER

Jacob Webb.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

New Jersey.

12 MAIDEN NAME OF MOTHER

Hannah Leak.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

New Jersey.

14

Informant: Michael Webb. (brother)

(Address) 8 W. Henrietta St.

15 Filed.....

19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928  
April 27, 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry

and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Illuminating Gas Asphyxia.  
Accidental Death.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

4/23 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

In the

of death.....yrs. ....mos. ....ds. State yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL

Dubois Pa

April 28 1928

20 UNDERTAKER

John F Denny

ADDRESS

715 E. 4th St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33354

## CERTIFICATE OF DEATH

E 33354

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 47 St. 47 Ward)2-FULL NAME Arthur Harris

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. Pasadena, Md St.      Ward     

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day—hrs. or—min..

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md

10 NAME OF FATHER

James Harris

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Anna Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

James Harris Pasadena Md

15 Filed

1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/28

17

I HEREBY CERTIFY, That I attended deceased from

4/22/28, 1928, to 4/27/28, 1928,that I last saw him alive on 4/27/28, 1928,and that death occurred, on the date stated above, at 9:30 a.m. m.

The CAUSE OF DEATH\* was as follows:

Pneumococicmeningitis(duration) yrs. 21 mos. 21 ds.

CONTRIBUTORY (Secondary)

Exhaustion(duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?    Date of   Was there an autopsy?   What test confirmed diagnosis? Clinical(Signed) J. E. Winstead, M. D.. 19 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

Date of Burial

20 UNDERTAKER

J. H. Brown

ADDRESS

1017 N. ...

913599  
E 33355

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

+ 84E 33355

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST., 7-9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Perry Woodyard

## (a) RESIDENCE NO.

Weston W-2a

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

7

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day... hrs. or min.

49

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

West 2a -

## 10 NAME OF FATHER

William

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

W-2a -

## 12 MAIDEN NAME OF MOTHER

Minerva Smith

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

W-2a -

## 14

Informant (Address)

Records -

## 15

Filed

C. HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 28 1928

## 17

I HEREBY CERTIFY, That I attended deceased from April 21, 1928, to April 28, 1928, that I last saw him live on April 28, 1928,

and that death occurred, on the date stated above, at

12 00 m.

The CAUSE OF DEATH\* was as follows:

Brain tumor - chronic Right Temporal lobe

(duration) 2 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Pneumonia

(duration) 4 yrs. mos. 2 ds.

## 18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? Yes Date of 4/24/28

Was there an autopsy? Yes

What test confirmed diagnosis?

Autopsy &amp; Operation

(Signed)

J. S. Jones

M. D.

4/28/28 Address Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Weston W 2a

April 29/28

## 20 UNDERTAKER

Joseph Ahrens

## ADDRESS

221 Broadway

## HEALTH DEPARTMENT - CITY OF BALTIMORE

E 33356

## CERTIFICATE OF DEATH

45 E 33356

1-PLACE OF DEATH

Md. Jew. Hospital

REGISTERED NO.

City of BALTIMORE: (No.

Cor. Linderus Madison St., 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hunter Boyd Gainer

(a) RESIDENCE NO.

2930 N. Calvert St.

Ward

(Usual place of abode)

unknown

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Clara B Gainer

6 DATE OF BIRTH (month, day, and year)

January 8, 1859

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

69 3 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wholesale Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Winchester

(State or country)

Virginia

10 NAME OF FATHER

James Gainer

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Catherine Anderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

Hospital Records

15

Filed

1928

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr 17, 1928, to Apr 27, 1928

that I last saw him alive on April 27, 1928

and that death occurred, on the date stated above, at 2:20 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma sigmoid

CONTRIBUTORY (Secondary)

unknown (duration) yrs. mos. ds.

Intestinal Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? Yes, a Partial autopsy

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park Cemetery 4/30, 1928

20 UNDERTAKER

ADDRESS

Henry W. Mears 805 N. Calvert

E 33357

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33357

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 St. Paul ST., 45 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice S. Felton

(a) RESIDENCE NO. 412 St. Paul ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Franklin C. Felton

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1851

7 AGE Years 77 Months 3 Days 11 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Halifax (State or country) Pennsylvania

10 NAME OF FATHER Joseph Loudermilch

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania (State or country)

12 MAIDEN NAME OF MOTHER Susan Wingard

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania (State or country)

14 Informant Mrs. Dolly Peerman (Address) Highspire, Pa.

15 Filed 1928 HAMMON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28 1928

17 I HEREBY CERTIFY, That I attended deceased from Apr. 2, 1928, to April 28, 1928, that I last saw her alive on April 24, 1928, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH\* was as follows:

Exhaustion - Heart failure and Pneumonia. Deceased has been in failing health for months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dangerous Growth in Transverse Colon (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At 412 Saint Paul.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Auricular - Digital (Signed) Anna L. Jones, M. D.

19 (Address) 618 N. Patuxent St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Lorraine Cemetery

DATE OF BURIAL

5/1 1928

20 UNDERTAKER

Henry W. Mears &amp; Son 805 N. Calvert



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33358

## CERTIFICATE OF DEATH

31 E 33358

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2444 Druid Hill St., 13-59 Ward)2-FULL NAME Milton Williams(a) RESIDENCE NO. 2444 Druid Hill St., 13-59 Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

Col

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 8 - 1922

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

6219

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

10 NAME OF FATHER

Matthew Morris

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Mary Braxton

13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

Va

14

Informant (Address)

Mary Williams  
2444 Druid Hill

15 Filed

C. HAMPSON JONES, M. D.  
Russ Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 27 19 28

17

I HEREBY CERTIFY That I attended deceased from

Apr 1 19 28 to Apr 27 19 28that I last saw him alive on Apr 20 19 28and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Phthisis  
(duration) 27 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

B. J. Hatcher M. D.  
4/28, 1928 (Address) 1115 Dunbar

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Albans Apr 29 19 28

20 UNDERTAKER

ADDRESS

Franklin W. Seitz 709 W. 33rd

Very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33359

## CERTIFICATE OF DEATH

1733 Linden Ave  
101-001  
E 33359

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 John St. 14-70 WARD)

2—FULL NAME Katherine R. Richardson

(a) RESIDENCE NO. 1524 John ST. WARD

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

a If married, widowed, or divorced  
HUSBAND of William H. Richardson  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 20, 1833

AGE Years 95 Months 2 Days 8 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town; State or country) Md

10 NAME OF FATHER George W. Hanson

11 BIRTHPLACE OF FATHER (city or town; State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Wilmer

13 BIRTHPLACE OF MOTHER (city or town; State or country) Md

Informant Mrs. M. J. Richardson  
(Address) 1035 N. Calvert St.

Filed 19 HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to April 28, 1928, that I last saw her alive on April 28, 1928, and that death occurred, on the date stated above, at 1:20 P. M.

The CAUSE OF DEATH\* was as follows:

Senility  
Terminal Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. M. Jones

4/28, 1928 (Address) 1733 Linden Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

London Park

Apr 30 1928

20 UNDERTAKER

ADDRESS

502 E North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33360

## CERTIFICATE OF DEATH.

74-001  
E 33360  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp. 15-21 Ward 15-21)2-FULL NAME Wm F. Marx(a) RESIDENCE NO. 1703 W. North Ave Ward 15-21

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 9 mos. 7 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)Male White Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofStella Marx

6 DATE OF BIRTH (month, day, and year)

July 21-1870

7 AGE

Year

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.56 9 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Salesman

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md. Apr 28-192710 NAME OF FATHER Fred Marx

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany12 MAIDEN NAME OF MOTHER Madia Whitch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

PARENTS

14 Informant  
(Address)Stella Marx  
1703 W. North Ave

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## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *912 E. Preston St.* ST. *9-12* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *912 E. Preston St.* St.; yrs., mos. ds.)REGISTERED NO. C. *33361*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED,  
OR SEPARATED,  
(Write the word.)

6-DATE OF BIRTH,

*4* *28*, *1928*  
(Month) (Day) (Year)

7-AGE,

yrs. mos. ds.

If LESS than 1 day,  
6 hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.....  
(b) General nature of industry, business,  
or establishment in which  
employed (or employer).....9-BIRTHPLACE,  
(State or Country),*Balt Md*10-NAME OF  
FATHER,*Wm G. King*11-BIRTHPLACE  
OF FATHER  
(State or Country),*Howard Co. Md.*12-MAIDEN NAME  
OF MOTHER*Elle E. Harwood*13-BIRTHPLACE  
OF MOTHER  
(State or Country),*Fredrick Co.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William A King*(Address) *912 E Preston*

15-

*229 1928* HAMPTON JONES, M. D.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*4* *28*, *1928*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*4/24/28* 191 to *4-28/28* 191  
that I saw him alive on *7/28/28* 191  
and that death occurred, on the date stated above, at *8 1/2* p. m.  
The CAUSE OF DEATH\* was as follows:*premature birth*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Lemard E. Beach M.D.**4/29/28*, 191... (Address) *222 E. St Paul St.*\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-  
FERRANTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*St Marys Hospital**April 28, 1928*

20-UNDERTAKER

ADDRESS

*George Schelling 1305 1/2 E Monument*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33362

## CERTIFICATE OF DEATH.

185 E 33362

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital Ward 30)2-FULL NAME Christ Morgan(a) RESIDENCE NO. 653 W. Lombard Ward       

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of       

6 DATE OF BIRTH (month, day, and year) December

7 AGE Years 69 Months        Days        IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly(b) General nature of industry, business, or establishment in which employed (or employer) Hospital(c) Name of employer University Hospital

9 BIRTHPLACE (city or town)

(State or country) Lithuania10 NAME OF FATHER Eckman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Eckman12 MAIDEN NAME OF MOTHER Eckman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Eckman

14

Informant (Address) Hospital Record  
University Hospital

15

Filed

19 HANSON JONES, M. D.

Registrar

REGISTERED NO.       

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death of the day stated above.

The CAUSE OF DEATH\* was as follows:

Lung Abscess

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Fall from Roof - Fracture

(duration) yrs. mos. ds.

(Signed) Eugene Jell M. D.

(Coroner)

(Address) 12739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?       Former or usual residence       

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Apr 30, 1928

20 UNDERTAKER

ADDRESS

John Grebiliankas 423 Spaulding St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33363

## CERTIFICATE OF DEATH.

50 E 33363

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

61 yrs.

mos.

4 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Alexander G. Welsh

6 DATE OF BIRTH (month, day, and year)

April 23-1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md

10 NAME OF FATHER

Thomas Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

Md

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

Md

14

Informant (Address)

Alexander G. Welsh Jr  
707 Millcrest drive

15

Filed

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 16, 1928, to April 27, 1928,

that I last saw her alive on April 27, 1928,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Abdominal tumour nature? (duration) yrs. mos. ds.

18 Where was disease contracted at home if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Hamlin, M. D.

19 (Address) Church Home &amp; Infirmary

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Habelawn Cemetery

April 30 1928

20 UNDERTAKER

ADDRESS 1203

J. Henry Lutz

N. Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33364

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ruth Umpleby

## (a) RESIDENCE NO.

Sisterville, W. Va.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

female white

married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

J. G. Umpleby

## 6 DATE OF BIRTH (month, day, and year)

1878

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

50

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

W. Va.

## 10 NAME OF FATHER

Hale - ?

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

?

## 12 MAIDEN NAME OF MOTHER

Lethie Prettyman

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ohio

## 14

Informant  
(Address)Records  
JOHNS HOPKINS HOSPITAL

## 15

Filed

19

HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 29 1928

## 17

I HEREBY CERTIFY, That I attended deceased from April 26, 1928, to April 29, 1928, that I last saw her alive on April 29, 1928, and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH\* was as follows:

Brain tumor - cerebellum -  
Pontine angle tumor, right  
Benign

(duration) 2 yrs. ? mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death?

Yes

Date of April 28, 1928

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical &amp; Operative

(Signed) F. D. Coman, M. D.

4/29/29 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Sisterville - W. Va.

Apr 29 1928

## 20 UNDERTAKER

## ADDRESS

J. O. Mitchell &amp; Sons

1900 Euter

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33365

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 345 Ewing Ave St. 70-70 Ward)2-FULL NAME Ruth Rose Mary O'Connor(a) RESIDENCE NO. 345 Ewing Ave St. 70-70 Ward(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO. E 33365

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) None6 If married, widowed, or divorced HUSBAND of (or) WIFE of None6 DATE OF BIRTH (month, day, and year) 9 7 19207 AGE Years 8 Months 1 Days 20 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) None(c) Name of employer None

## 9 BIRTHPLACE (city or town)

(State or country) Baltimore Md10 NAME OF FATHER Ed O'Connor Jr.11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Rebecca Parsons13 BIRTHPLACE OF MOTHER (city or town) Ward  
(State or country)14 Informant Charles Frederick O'Connor Jr.  
(Address) 345 Ewing Ave15 Filed 29 1928 HANCOCK JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 192817 I HEREBY CERTIFY, That I attended deceased from April 17, 1928, to April 27, 1928, that I last saw him alive on April 26, 1928, and that death occurred, on the date stated above, at 12:10 a. m.

The CAUSE OF DEATH was as follows:

InfluenzaCONTRIBUTORY (duration) 10 yrs. 10 mos. 10 ds.  
(Secondary) Tuberculosis & Cancer(duration) 10 yrs. 10 mos. 10 ds.

18 Where was disease contracted

If not at place of death? NoneDid an operation precede death? No Date of NoneWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Benjamin M. Carey, M. D.  
28. 1928 (Address) 400 N. Baydon St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Lorraine Park Cemetery April 30 1928  
20 UNDERTAKER Chas. G. Black 742 W. North Ave



E 33366

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

Franklin Sq. Hospital 21-31 St., Ward

## 2-FULL NAME

Jerome F Bradley

(a) RESIDENCE NO.

1024 Russell

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 7 mos. 25 ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year)

Sept 12 1903

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

24

7

25

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

B &amp; O R.R.

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

10 NAME OF FATHER

John J Bradley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Anna M. Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant (Address)

John J Bradley  
1024 Russell St

15

Filed

1928 C. HAYDON JONES, M.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Motor cycle acc.  
Fracture of Skull

CONTRIBUTORY (Secondary)

28 yrs 9 to blades (Coroner's M. D.)

19

(Address)

143 W 100 Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Cathedral

4-28-28

20 UNDERTAKER

ADDRESS

Edward C. Harbo 1000 St Paul St

E 33367

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33367

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3809 Chatham Rd ST. 15 WARD 6)2-FULL NAME William S. McCombs(a) RESIDENCE NO. 3809 Chatham Rd WARD 6  
(Usual place of abode)Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced, HUSBAND of (or) WIFE of R. Eliza McCombs6 DATE OF BIRTH (month, day, and year) Jan 4 18507 AGE Years 78 Months 3 Days 24 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa10 NAME OF FATHER A. P. McCombs11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.12 MAIDEN NAME OF MOTHER Maria Schott13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.14 Informant Mrs J. C. Brown (Address) 3809 Chatham Rd15 Filed 1928 REGISTRAR HAMPTON JONES, M.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 192817 I HEREBY CERTIFY, That I attended deceased from April 28, 1928 to April 28, 1928, that I last saw him alive on April 28, 1928, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:

Coronary Sclerosis & EmbolismCONTRIBUTORY (Secondary) Myocarditis & Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clara Quinn M. D.4721 (Address) 4702 Hampden Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL DATE OF BURIAL

Angel Hill - Mount St. Mary's 5-1 1928

UNDERTAKER ADDRESS

J. A. Pennington St. Mary's

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33368

## CERTIFICATE OF DEATH.

129 E 33368

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1806 Rutland Ave St. 8-17 Ward)

2-FULL NAME Edward Augustus Zile

(a) RESIDENCE NO. 1806 Rutland Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mary E. Zile

6 DATE OF BIRTH (month, day, and year) July 19/1844

7 AGE Years 83 Months 9 Days 10 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 06

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Carroll Co., Md.

10 NAME OF FATHER David Zile

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER Elizabeth Parrish

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14 Informant Mrs. Robert E. Foutz (Address) 1806 Rutland Ave

15 Filed 29 1928 HAMMOND JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29-1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis- Chr. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY Senility (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Patton M. D.

(Coroner)

4/29/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co. Md. Date of Burial May 2-1928

20 UNDERTAKER C. M. Hatz

ADDRESS

C. M. Hatz: Hainfield Md.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33370  
1-PLACE OF DEATHCITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *6-9* WARD)2-FULL NAME *Edith Weiss*(a) RESIDENCE NO. *406 N. Broadway* ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Aug. 13, 1926*

7 AGE

Years

Months

Days

If LESS than 1 day... hrs. or... min.

*1**8**16*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*10 NAME OF FATHER *Israel Weiss*11 BIRTHPLACE OF FATHER (city or town) *Russia*  
(State or country)12 MAIDEN NAME OF MOTHER *Betty Fligert*13 BIRTHPLACE OF MOTHER (city or town) *Russia*  
(State or country)14 Informant *Mrs. Israel Fligert*  
(Address) *406 N. Broadway*15 *PR 29 1928* *HAMPSON JONES, M. D.*  
Filed. *19* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 29, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 16*, 1928, to *April 29*, 1928, that I last saw her alive on *April 29*, 1928, and that death occurred, on the date stated above, at *7 25 a. m.*

The CAUSE OF DEATH\* was as follows:

*Relieved Bronchopneumonia*(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *35* ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? *At home*Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *None*(Signed) *Dr. J. L. Levin*, M. D.4-29, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Henry Rosedale**4-29-1928*

## 20 UNDERTAKER

ADDRESS

*Jack Lewis, 1424 E. Balt.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33371

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3201 E. Pratt

2. FULL NAME JOHN L. FRANCE

(a) RESIDENCE No. 3201 E. Pratt

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 16, 1917

7 AGE Years 10 Months 7 Days 12 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Charles W. France

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Mary S. Tarr

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs. Mary S. Tarr (Mother)  
(Address) 3201 E. Pratt St.

15 Filed 29 1928 H. JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1928, to April 27, 1928, that I last saw him alive on April 27, 1928, and that death occurred, on the date stated above, at 11.10 p. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia  
Lobar

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? w Date of

Was there an autopsy? w

What test confirmed diagnosis?

(Signed) Dr. L. J. Zimmerman, M. D.

4/27/28 (Address) 7458 Harford Rd  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL  
Baltimore Cemetery

DATE OF BURIAL

April 30 1928

20 UNDERTAKER

Henry Sander &amp; Sons, Inc.

ADDRESS BALTIMORE ST &amp; BROADWAY

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33372

## CERTIFICATE OF DEATH.

E 33372

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3417 E. Baltimore

ST. 26-37 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME CHARLES SOMMERS

(a) RESIDENCE No. 3417 E. Baltimore

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ST. WARD

(If non-resident give city or town and State) ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Sommers

6 DATE OF BIRTH (month, day, and year) April 3, 1849

7 AGE

Years 79

Months 0

Days 22

If LESS than t day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Caulker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 2 years

(c) Name of employer Maryland Dredging Co.

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Martin Sommers

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14

Informant Mrs. Tillie Hilgeman (Daughter) (Address) 3417 E. Baltimore St.

15

Filed 1923

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1928

17

I HEREBY CERTIFY, That I attended deceased from May - 1926 to April 25 - 1928, that I last saw him alive on April 24 - 1928 and that death occurred, on the date stated above, at 12.45 a. m.

The CAUSE OF DEATH\* was as follows:

Corio-Vascular Dis - Atheroma

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds. Atheroma (Congestion) Lungs

18 Where was disease contracted if not at place of death? (duration) yrs. mos. da.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Anal

(Signed) J. P. B. Resler, M. D.

19 (Address) 125 S Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Carmel Cemetery

DATE OF BURIAL

Apr. 29, 1928

20 UNDERTAKER

Henry Sander &amp; Sons Inc

ADDRESS BALTIMORE ST. &amp; BROADWAY

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33373

## CERTIFICATE OF DEATH.

129 ✓  
E 33373  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1030 N. Washington St., 7-13 Ward)

2-FULL NAME THOMAS G. SWAYNE

(a) RESIDENCE NO. 1030 N. Washington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Swayne

6 DATE OF BIRTH (month, day, and year) October 7, 1886

7 AGE Years 44 7 Months 6 Days 20 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Standard Oil Co., (N.J.)

9 BIRTHPLACE (city or town) Baltimore

(State or country)

10 NAME OF FATHER James Swayne

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. Mary R. Swayne (Wife) (Address) 1030 N. Washington St.

15 Filed..... 19 Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27<sup>1928</sup>

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chr. Nephritis

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed) J. J. Porter (Coroner) M. D.

4/28/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL OAK LAWN CEMETERY. Date of Burial April 30, 1928

20 UNDERTAKER Henry Sander & Sons Inc ADDRESS BALTIMORE ST. & BROADWAY.



*May B. Wagner*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33374

## CERTIFICATE OF DEATH.

129 E 33374  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1158 Longwood* St. *16-67* Ward)2-FULL NAME *May B. Wagner*(a) RESIDENCE NO. *1158 Longwood* St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed, or divorced, HUSBAND of *John W. Wagner* (or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year) *Feb 7-1862*7 AGE Years *66* Months *2* Days *20* IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Homework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)10 NAME OF FATHER *Geo. Gaspich*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *John W. Wagner* (Address) *1158 Longwood*15 Filed for burial by *G. HAMPTON JONES, M. D.*

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 27* 1928

I HEREBY CERTIFY, That I took charge of the remains described above, held an \_\_\_\_\_ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said \_\_\_\_\_ (Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*Chronic Interstitial Nephritis* (duration) *One* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

(Signed) *A. C. Lank* (Address) *Baltimore* (Coroner) M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Stone Chapel*20 UNDERTAKER *Harry C. Branning*

Date of burial

*4/30th 1928*ADDRESS *Poplar**1136 Grove St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33375

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 33375

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 8-12 Ward)2-FULL NAME John D. Baker(a) RESIDENCE NO. 1025 N. Milton Ave St.        Ward       

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 1/19117 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
17 3 26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman(b) General nature of industry, business, or establishment in which employed (or employer) Paint & Oils

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.10 NAME OF FATHER J. Bernard Baker11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Md.12 MAIDEN NAME OF MOTHER Lula M. Kanode13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Md.

14

Informant Father  
(Address)

15 Filed

23 1928HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-  
topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidentally burned over body.(Spilled furniture Polish on stove at home)  
(duration) .....yrs. ....mos. ....ds.CONTRIBUTORY  
(Secondary)(Signed) J. S. Jones

(Coroner)

4/29/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

George A. Taylor 4/30/28  
Fulton Taylor

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

✓ 33376.

E 33376

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)ST. 79 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ray H. Smith(a) RESIDENCE NO. Walstonburg Green St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male white married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Delia

6 DATE OF BIRTH (month, day, and year)

11-19-79

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45 5 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N.C.

10 NAME OF FATHER

Clay Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Sara Fields

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.C.

14

Informant (Address)

Records

15

Filed

19

HANDBY JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1928

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1928, to April 29, 1928, that I last saw him alive on April 29, 1928, and that death occurred, on the date stated above, at 550 a.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Bladder.  
(Malignant Tumor).

(duration)

1 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Paralytic Ileus.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes, Date of Apr. 28, 1928.Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

Walstonburg N.C.April 28

UNDERTAKER

William S. Schaeffer

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33377

## CERTIFICATE OF DEATH.

E 33377

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *md. Gen Hosp 24-33* St. *Ward*)

2-NAME OF DECEASED

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

33 yrs. 7 mos. 14 ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)*male white Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Marie L. Wehberg*

6 DATE OF BIRTH (month, day, and year)

*Sept 13-1891*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.*36 7 14*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

*Rigger*

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore Md*

10 NAME OF FATHER

*Theo. Wehberg*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Josephine Faugman*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant  
(Address)*Marie L. Wehberg  
1138 River Side*

15 Filed

19

*HAMMON JONES, M. D.  
Registrar*

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest*  
(Inquest, au-topsy or inquiry.) and that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

CONTR

(duration) yrs. mos. ds.

*Crushed Elbow. due to injury*

(duration) yrs. mos. ds.

*Disputed*(Signed) *F. E. Lick* M. D.(Address) *Coroner*\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

When was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL *May Brial**Holy Cross Cemetery April 1928*

20 UNDERTAKER

*Fred A. Trauer & Son 703 Hanover*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 33378**

## CERTIFICATE OF DEATH.

**E 33378**

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 7-13 Ward)

2-FULL NAME Thomas W. Buckmaster

(a) RESIDENCE NO. 2060 E. Eager St. St. Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)

male

white

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Selma L. Buckmaster

6 DATE OF BIRTH (month, day, and year)

Oct 29/1892

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

35

5

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Carpenter

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

10 NAME OF FATHER

John R. Buckmaster

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

11

14

Informant  
(Address)

Wife

15

Filed

C. H. JONES, M. D. Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 26/28

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy, or inquiry.)thereon and from the evidence obtained by said  
inquiry and that said deceased came to his death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Frac Skull - Lacerated Brain Autop by  
Struck by automobile 421 N. Broad-  
way.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

In the

of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Mt Olivet Cemetery April 30/28

20 UNDERTAKER

ADDRESS

Fred. A. Kramer &amp; Son 105 Hanover

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33379  
PLACE OF DEATH

E 33379

CITY OF BALTIMORE: (No. U.S. Marine Hospital

ST. 17-51 WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

2-FULL NAME Ernest H. Crooks

(a) RESIDENCE No. Crisfield, Md.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 2 mos.

20s.

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 31 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Mrs. Nellie C. Crooks

6 DATE OF BIRTH (month, day, and year) July 21, 1878

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

49

49

9

7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Steward - seaman

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Seaman

(c) Name of employer Sch. J.W. Wilson

9 BIRTHPLACE (city or town)  
(State or country)

England

10 NAME OF FATHER Matthew Crooks

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

England

12 MAIDEN NAME OF MOTHER Jane Sylvester

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

England

14

Informant  
(Address)

Records, U.S. Marine Hospital

15

Filed

R 30 1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
February 10, 19 28, to April 28, 19 28,that I last saw him alive on April 28, 19 28,  
and that death occurred, on the date stated above, at 1:30 a. m.The CAUSE OF DEATH\* was as follows:  
Carcinoma of the tongue  
Metastases of neck

(duration) yrs. 11 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Crisfield, Md.

Did an operation precede death? NO Date of \_\_\_\_\_

Was there an autopsy? NO

What test confirmed diagnosis? Physical examination

(Signed) *Charles H. Jones*, M. D.

, 19 (Address) U.S. Marine Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

125 North  
ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33380

## CERTIFICATE OF DEATH.

90 E 33380

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2801 Grindon Ave

ST. 27-44 WARD)

## 2-FULL NAME

William W. Swift

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

2801 Grindon Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

26/4

yrs.

21 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Carrie Swift

## 6 DATE OF BIRTH (month, day, and year)

Dec 5 1866

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

61 5 21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Flour Salesman

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

## 10 NAME OF FATHER Chaney H. Swift

11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

## 12 MAIDEN NAME OF MOTHER Mariar Fuller

13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)

## 14

Informant  
(Address)Mrs. Swift  
2801 Grindon Ave

## 15

Filed

19

H. M. K. R. E. S. M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) 4-26 1928

## 17

I HEREBY CERTIFY, That I attended deceased from  
May 30, 1925, to Apr 26, 1928.

that I last saw him alive on Apr 25, 1928

and that death occurred, on the date stated above, at 5-P. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis chronic

(duration) 3 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

James C. Clarke, M. D.

4-27, 1928 (Address)

Latrobe Apt

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

M. Oliver &amp; Co

4/30 1928

## 20 UNDERTAKER

## ADDRESS

J. Frew M. Gully

130 E. Fort

## HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 33381**

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Maryland Gen. Hospital* Ward)2-FULL NAME *Kilda Hardem*(a) RESIDENCE NO. *Garrison Md.*

(Usual place of abode)

St. Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *23* ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 Color or Race

*white*

5 Single, Married, Widowed, or Divorced. (write the word)

*single.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Aug 7, 1902*

7 AGE

*25*

Years

Months

Days

*8**21*

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Home girl.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Carroll Co. Md.*

10 NAME OF FATHER

*Tyron Hardem*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Garrison Md.*

12 MAIDEN NAME OF MOTHER

*Blanche Horner*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Carroll Co. Md.*

14

Informant (Address)

*Hapt Records*

15 Filed

*R 30 1928*

19

Per

*HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*Apr. 28, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *4/5*, 19*28*, to *4/28*, 19*28*.that I last saw him alive on *4/28*, 19*28*.and that death occurred, on the date stated above, at *8:25 A.m.*

The CAUSE OF DEATH\* was as follows:

*Paraneoplastic nephritis*

CO. (duration)

yrs. *4* mos. ds.

(Secondary)

18 Where was disease contracted

if not at place of death?

*At home*Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

Per

*Home Chapel Kennedy April 30 1928*  
*Baltimore Co. Md.*  
*J. F. Eburne Rutherford Md.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

**E 33382**  
1-PLACE OF DEATH129 **E 33382**  
REGISTERED NO.City of BALTIMORE: (No. 37 S Ann St Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin W E Dippel(a) RESIDENCE NO. 37 S Ann St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married16 DATE OF DEATH (month, day, and year) Apr. 27 19 285a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Annie M Dippel6 DATE OF BIRTH (month, day, and year) July 29 186717 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1928, to Apr 27, 1928,  
that I last saw him alive on Apr 26, 1928,  
and that death occurred, on the date stated above, at 6 30 m.7 AGE 60 Years 8 Months 28 Days  
IF LESS than  
1 day 0 hrs.  
or 0 min..

The CAUSE OF DEATH\* was as follows:

Cardiac Hypertrophy  
Myocarditis  
Nephritis

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY  
(Secondary) Coronary Thrombosis9 BIRTHPLACE (city or town)  
(State or country) Balto

18 Where was disease contracted

if not at place of death?

10 NAME OF FATHER Wendell DippelDid an operation precede death? no Date of —11 BIRTHPLACE OF FATHER (City or town)  
(State or country) GermanyWas there an autopsy? no12 MAIDEN NAME OF MOTHER Mary SurtzerWhat test confirmed diagnosis: Clinical Exam & Pathology  
(Signed) A. F. Ries, M. D.13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Balto(Address) 24 S. Perry14 Informant Martin J Dippel  
(Address) 37 S Ann St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy RedeemerDate of Burial May 1 192815 Filed 30 1928 19 HAMISON JONES M. D.  
Registrar R. K. K.20 UNDERTAKER George J. PughADDRESS 1735 N. Cal

Very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33383

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 N. Caroline ST. 8-17 WARD)2-FULL NAME Romenica Piraino Papania(a) RESIDENCE NO. 1221 N. Caroline ST., 8-17 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced, HUSBAND or WIFE of Samuel Papania6 DATE OF BIRTH (month, day, and year) June 13, 18357 AGE 92 Years93 Months10 Days15 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) (State or country) Italy10 NAME OF FATHER Joseph Piraino11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy12 MAIDEN NAME OF MOTHER Sanson13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy14 Informant (Address) Samuel Papania, 1221 N. Caroline St.15 Filed 1919HAMMONDJONESM. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28- 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 24 - 1928, to Apr. 28 - 1928, that I last saw her alive on Apr. 28 - 1928, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH\* was as follows:

Arterial Sclerosis  
not hemorrhagic(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) Edwin B. Ferby M. D.4/28/1928 Address 1223 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer4/30 1928

20 UNDERTAKER

ADDRESS

George J. Ruth 17301 Harborview

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33384

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9437 of Calvert ST. 11-15 WARD)

2-FULL NAME Mary E. Lovering

(a) RESIDENCE No. 9437. Calvert ST.

(Usual place of abode)

Length of residence in city or town where death occurred

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single Married Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Late Frank Lovering

6 DATE OF BIRTH (month, day, and year)

Feb 15 / 1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

61

9

11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sole

(b) General nature of industry, business, or establishment in which employed (or employer)

L-Body. det

(c) Name of employer

Bragg &amp; Wap.

9 BIRTHPLACE (city or town) (State or country)

Balt.

10 NAME OF FATHER

Frank Lovering

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Mrs. Harry Davis 2003

15

Filed

R 30 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 27 1928

17 I HEREBY CERTIFY, That deceased from

that I last saw him alive on

Apr 25 1928

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4259

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmount Cemetery

Apr 30 1928

20 UNDERTAKER

George J. Pugh 1735 Harford

E 33385

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33385

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5105 Audmoreway ST. 27-41 WARD)

2-FULL NAME William J Callis

(a) RESIDENCE No. 5105 Audmoreway ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? Life yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/10/1851

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER George R Callis

11 BIRTHPLACE OF FATHER (city or town) Balto Md. (State or country)

12 MAIDEN NAME OF MOTHER Johanna Callis

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Mrs George W Rhinehardt (Address) 5105 Audmoreway

15 Filed 1928, 19 C. HAMMOND JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1928, to April 27, 1928,

that I last saw him alive on April 27, 1928

and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH\* was as follows:

Acute Dilatation of Heart

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Pulmon Embolus

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Harding, M. D.

19 (Address) 4919 Belair Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

5/1 1928

20 UNDERTAKER

ADDRESS

Albert L Hiltz Jr 1606 N Chester St



E 33386

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33386

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 Brewer St St. 17-14 Ward)

Registered No. ....

2-FULL NAME Francis Bishop

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1102 Brewer St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Black 5-Single, Married, Widowed, Divorced (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 4/25/287-AGE. 4 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. nc

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md10-NAME OF FATHER Arthur Thomas11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md12-MAIDEN NAME OF MOTHER Edna Bishop13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md14- (Informant) Edna Bishop (Address) 1102 Brewer St15- C. HAMMOND JONES, M.D. Registrar. Filed 30 1928

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 4/29/2817- I HEREBY CERTIFY, That I attended deceased from 4/25 19 28 to 4/29 19 28 that I last saw him alive on 4/29 19 28 and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH\* was as follows:

Congenital Atherosclerosis  
(prematurity)

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted? If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical signs(Signed) Jus. J. H. Hitts M. D.19 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Andrew's 4/30 19 28

20-UNDERTAKER

ADDRESS

St. Andrew's Dr. Jones



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33388

## CERTIFICATE OF DEATH

90 E 33388

1-PLACE OF DEATH

Jenkins Memorial Hospital

REGISTERED NO.

City of BALTIMORE: (No.

1000 Caton Ave St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William H. Doe

(a) RESIDENCE NO.

206 East 20th

St. Pat. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 18, 1866

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min..

61

11

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

City Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

City of Baltimore

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Md.

10 NAME OF FATHER

William R. Doe

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Bermuda

12 MAIDEN NAME OF MOTHER

Olive R. Booley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant  
(Address)Jenkins Memorial Hosp  
1000 Caton Ave Balt

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 3, 1927, to April 29, 1928

that I last saw him alive on April 29, 1928

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis  
Chronic Arteritis

(duration) yrs. mos. ds.

CONTRIBUTORY Bronch. pneumonia

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? 710 Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis J. Badalucco, M. D.

19

(Address)

St. Agnes Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Greenmount

May 1, 1928

20 UNDERTAKER

ADDRESS

J. H. Cook

302 E North Ave

See instructions on back of certificates.

PARENTS

APR 30 1928

HAMPDEN JONES, M. D.  
Registrar

8/35-38  
E 33389

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 ✓  
E 33389

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 9-46 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Eva Byere

(a) RESIDENCE NO. 501 East 28th

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced

(or) WIFE of Percy Byere

6 DATE OF BIRTH (month, day, and year) 5-29-04

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

24<sup>23</sup> 11 29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

10 NAME OF FATHER Louis Schenkinger

11 BIRTHPLACE OF FATHER (city or town) Md

12 MAIDEN NAME OF MOTHER Rosa Frank

13 BIRTHPLACE OF MOTHER (city or town) Md

14 Informant Records

(Address)

15 Filed 19 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28 1928

17 I HEREBY CERTIFY, That I attended deceased from 4/27, 1928, to 4/28, 1928,

that I last saw him alive on 4/28, 1928, and that death occurred, on the date stated above, at 7:00 p.m.

The CAUSE OF DEATH\* was as follows:

Brain Lumen-Dural Endothelial Rupture Left frontal

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/28/28

Was there an autopsy? No

What test confirmed diagnosis? Clinical &amp; Operative

(Signed) F. L. Cowan, M. D.

4/28/28 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

MOVAL

Baltimore

Apr 28 1928

20 UNDERTAKER

J. M. Cook

ADDRESS

202 E. North Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33390

## CERTIFICATE OF DEATH.

90 E 33390

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2725 Edmondson Ave ST. 10-69 WARD)2. FULL NAME Barbara Fleckenstein

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2725 Edmondson Ave ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred Lif yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. Single, Married, Widowed, or Divorced, (write the word) Widow5a. If married, widowed, or divorced late Aug. Fleckenstein(or) WIFE of late Aug. Fleckenstein6. DATE OF BIRTH (month, day, and year) Apr 8/86

7. AGE

Years

Months

Days

If LESS than 1 day. \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

72—18

## 8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (city or town) (State or country) City10. NAME OF FATHER John Liekhauf11. BIRTHPLACE OF FATHER (city or town) (State or country) Ger.12. MAIDEN NAME OF MOTHER Unknown13. BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14.

Informant (Address) Fred R. Fleckenstein  
2725 Edmondson Ave

15.

Filed 1928

19.

HAMMOND JONES, M. D.  
R. M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) Apr 26 19 28

17.

I HEREBY CERTIFY, That I attended deceased from Apr. 22, 19 28, to Apr. 26, 19 28.that I last saw her alive on Apr. 26, 19 28.and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH\* was as follows:

Myocardial DegenerationUnknown (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. Where was disease contracted

if not at place of death? UnknownDid an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Physical Signs(Signed) W. H. Triplett, M. D., 19 \_\_\_\_\_ (Address) 1324 W. Lombard St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR RE-MOVAL Balto

DATE OF BURIAL

4/30 19 28ADDRESS 2016Arleaus

20. UNDERTAKER

Philip Herwig

# Ahles

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33391

## CERTIFICATE OF DEATH.

7409 E 33391

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 817 WARD)2. FULL NAME Joseph Ahles

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2100 E. Baltimore St.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Nellie Ahles6 DATE OF BIRTH (month, day, and year) 18607 AGE 68 Years 67 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boatman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md10 NAME OF FATHER Geo F. Ahles11 BIRTHPLACE OF FATHER (city or town) (State or country) Md12 MAIDEN NAME OF MOTHER Mother13 BIRTHPLACE OF MOTHER (city or town) (State or country) Il14 Informant Ida Lewis (Address) 2332 N Fairview Pl15 1928 G. H. Jones, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/28 19 2817 I HEREBY CERTIFY, That I attended deceased from 4/22/28, 19 28, to 4/27/28, 19 28, that I last saw him alive on 4/27/28, 19 28and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH\* was as follows:

central hemorrhageCONTRIBUTORY (Secondary) cardiac dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Lawrence Faber, M. D., 19 (Address) St Joseph's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore CoApr 30 19 28

20 UNDERTAKER

ADDRESS

Geo M. F. Smith811 N. Wood

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33392

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1705 Mosher St. 16-22 Ward)

2-FULL NAME

Frederick Flowers(a) RESIDENCE NO. 1705 Mosher St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 5 mos. 6 ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

Nov 23-19277 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
5 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

10 NAME OF FATHER

Frederick Flowers

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

14

Informant (Address)

Frederick Flowers  
1705 Mosher

15

Filed....., 19

HAN RAY JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 192 817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au- (Inquest, au-  
topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Enteritis(duration) yrs. \_\_\_\_\_ mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

19

(Address)

F. C. Lusk M. D.

(Coroner)

Coroner

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State..... yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death:.....

Former or usual residence.....

PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt Auburn April 30 192 8

20 UNDERTAKER

ADDRESS

Virginia R. Brooks 1463 N. Carey

397  
H/33393

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33393

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITALST. 7-9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Fleck(a) RESIDENCE NO. 1 Dewey Ave

(Usual place of abode)

ST.

WARD Ellridge Rd

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 7

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male blackchild

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-23-27

7 AGE

Years

Months 5

Days

If LESS than 1 day... hrs. or min.

1155

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

md.

10 NAME OF FATHER

Frank Fleck

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Marie Cages

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md.

14

Informant (Address)

Records

15

Filed

HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 23, 1928, to April 28, 1928,that I last saw him live on April 28, 1928,and that death occurred, on the date stated above, at 6:35 P. m.

The CAUSE OF DEATH\* was as follows:

Pertussis(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

HomeDid an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

X-ray

(Signed)

J. C. Goodman

M. D.

4/28, 1928 (Address)

J. H. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR DATE OF BURIAL

St. James Chapel Apr 30, 1928

20 UNDERTAKER

ADDRESS 178Sumner P. Hensley





## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 33395

1-PLACE OF DEATH

## CERTIFICATE OF DEATH

74-001  
E 33395  
REGISTERED NO.

City of BALTIMORE: (No. 2132 Mt. Royal Terrace 13-59 Ward)

(2-FULL NAME Beale E. Riddle

(a) RESIDENCE NO. 2132 Mt. Royal Terrace St.

(Usual place of abode)

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race.

5 Single, Married, Widowed, or Divorced. (write the word)

Male white widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

66

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Salesman

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Beale E. Riddle

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

"

14

Informant (Address)

Charles E. Riddle 2132 Mt. Royal Terrace

15 Filed

19

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29 1928

17

I HEREBY CERTIFY, That I attended deceased from

August 1926 to April 29, 1928, that I last saw him alive on April 27, 1928, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 8 mos. - ds.

(duration) Many yrs. - mos. - ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Donald H. Peterson, M. D.

1811 W. Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Western Cemetery May 1 1928  
J. C. Mitchell & Sons 1204 N. Bayview

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33396

## CERTIFICATE OF DEATH.

E 33396

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hosp* ST. *25-72* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mr Matthew Weiss*(a) RESIDENCE NO. *4818 Osage Ave Phila. Pa.*

(Usual place of abode)

ST. *1* WARD

WARD

Length of residence in city or town where death occurred

yrs.

mos.

*3* ds.

Now long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male.**White**Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Josephine Weiss*

6 DATE OF BIRTH (month, day, and year)

*Unknown*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*33*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Salesman.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Wash. D. C.*

10 NAME OF FATHER

*Harris Weiss*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Russia*

12 MAIDEN NAME OF MOTHER

*Sarah*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Russia*

14

Informant  
(Address)*Albert Litcher  
Child PA 5708 Lombard St*

15

Filed

19. *HAMPSON JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 29 19 28*

17

I HEREBY CERTIFY, That I attended deceased from

*April 26<sup>th</sup>, 19 28, to April 29, 19 28,*that I last saw him alive on *April 29, 19 28*and that death occurred, on the date stated above, at *11 22 p. m.*

The CAUSE OF DEATH\* was as follows:

*Hypertrophoma of  
pancreas*(duration) yrs. *7* mos. *—* ds.CONTRIBUTORY  
(Secondary)(duration) yrs. *1* mos. *1* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *yes* Date of *4/27/28*Was there an autopsy? *No*What test confirmed diagnosis? *Microscopic**Augustine P. von Schmalz, M. D.**St. Agnes Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*NOVA  
West Child PA**4/30 19 28*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1409 E. Pratt St*

**E 33397**

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**31 E 33397**

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1231 N. Patterson Park Ave St. 8-16 Ward)2-FULL NAME Edna Marie Ammon(a) RESIDENCE NO. 1231 N. Patterson Park Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. - mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11 - 19097 AGE Years 18 Months 5 Days 17 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hand-filler(b) General nature of industry, business, or establishment in which employed (or employer) clothing(c) Name of employer Dress Co.9 BIRTHPLACE (city or town) York County  
(State or country) Pennsylvania10 NAME OF FATHER John H. Ammon11 BIRTHPLACE OF FATHER (city or town) York  
(State or country) Pennsylvania12 MAIDEN NAME OF MOTHER Lilly C. Deck13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland14 Informant Lilly C. Ammon  
(Address) 1231 N. Patterson Park Ave15 Filed 1928 HAMPSON JONES, M. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-192817 I HEREBY CERTIFY, That I attended deceased from November 23, 1926, to April 28, 1928, that I last saw her alive on April 27, 1928, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 2 yrs. - mos. - ds.CONTRIBUTORY (Secondary) none(duration) 2 yrs. - mos. - ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? physical signs(Signed) Chester R. Ireland, M. D.4-28, 1928 (Address) 2532 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Baltimore April 31 192820 UNDERTAKER Robert L. Lamm ADDRESS 1462 N. Broadway



**E 33398**

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 317 S. Highland Ave St., 26-2 Ward)2-FULL NAME Knute L. Hanson(a) RESIDENCE NO. 317 S. Highland Ave St. 26 Ward(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)Male WhiteSingle5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 27<sup>th</sup> 1926

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.142

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Infant

9 BIRTHPLACE (city or town)

(State or country)

Balto. Md.

10 NAME OF FATHER

Knute L. Hanson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Norway

12 MAIDEN NAME OF MOTHER

Sigrid Hartvigson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Norway

14

Informant

(Address)

Sigrid Hanson  
317 S. Highland Ave

15

Filed.....

19

HARVEY JONES, M. D.  
R. M. H. Registrar

REGISTERED NO.

**E 33398**(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28April 29

17

I HEREBY CERTIFY, That I attended deceased from

April 23, 1928, to April 29, 1928,that I last saw him alive on April 28, 1928,and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH\* was as follows:

MeaslesCONTRIBUTORY (duration) ..... yrs. .... mos. 25 ds.  
Broncho Pneumonia  
(Secondary)(duration) ..... yrs. .... mos. 10 ds.

18 Where was disease contracted

If not at place of death?

UnknownDid an operation precede death? No Date of.....Was there an autopsy? NoWhat test confirmed diagnosis? Observation

(Signed)

E. Horace B. Titlow, M. D.4/29, 1928 (Address) 315 S. Highland Ave\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Oak Lawn Cemetery Apr. 30 1928

20 UNDERTAKER

ADDRESS

Lilly & Feiler Inc. 403 S. Wolfe St

E 33399

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3707 Foster Ave.*)2-FULL NAME *Madeleine Goetz*(a) RESIDENCE NO. *3707 Foster Ave.*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *3* mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*January 27/28*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*3**2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

10 NAME OF FATHER

*John Goetz*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore, Md.*

12 MAIDEN NAME OF MOTHER

*Mary C. Hyland*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore, Md.*

14

Informant (Address)

*John Goetz 3707 Foster Ave.*

R 30 1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 29 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 23, 1928* to *April 29, 1928*, that I last saw her alive on *April 26, 1928*, and that death occurred, on the date stated above, at *3.50 a. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia (Bronchial)*(duration) yrs. mos. *8* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Geo. Lochbeck*, M. D., 19 (Address) *100 E. 34th St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Redeemer Church**Apr. 30 1928*

20 UNDERTAKER

ADDRESS

*Lilly & Zeiler Inc.**403 S. Wolfe St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33400

## CERTIFICATE OF DEATH.

E 33400

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 369 S. Ellamont ST. WARD)

2. FULL NAME Margaret Jane Reitterer

(a) RESIDENCE No. 369 S. Ellamont ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? (If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 22, 1928

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.  
(State or country) Md.

10 NAME OF FATHER Fredk. Reitterer

11 BIRTHPLACE OF FATHER (city or town) Balto.  
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Dorn

13 BIRTHPLACE OF MOTHER (city or town) Balto.  
(State or country) Md.14 Informant Fredk. Reitterer  
(Address) 369 S. Ellamont St.

15 Filed 19 H. H. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jul 28, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 26, 1928, to April 28, 1928,  
that I last saw him alive on April 28, 1928  
and that death occurred, on the date stated above, at 6 P. M.  
The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & X-ray  
(Signed) Walter A. Jones, M. D.

4/30, 1928 (Address) 57 Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Mount Olivet Cem. May 1, 1928

## 20 UNDERTAKER

## ADDRESS

Charles W. Dill Fredk. Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33401

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1602 W Fayette* *14-27* WARD)2-FULL NAME *Catherine C. Clark*(a) RESIDENCE NO. *1602 W Fayette* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred *59* yrs. *0* mos. *27* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

87 E 33401  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female white**Widow*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Wm. P. Clark (deceased)*

6 DATE OF BIRTH (month, day, and year)

*April 1, 1864*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*59**27*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*house work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

10 NAME OF FATHER

*Wm. M. Phillips*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore, Md.*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

14

Informant (Address)

*Mr. Wm. M. Clark, 1602 W Fayette St.*

15

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 28, 1928*17 I HEREBY CERTIFY, That I attended deceased from *Jan 1, 1928* to *April 28, 1928*, that I last saw him alive on *April 27, 1928*, and that death occurred, on the date stated above, at *7:30* m. The CAUSE OF DEATH\* was as follows:*Acute Pericarditis*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4/29/28

(Address)

*M. A. O'Neill, M. D., 108 N. Button Line*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*New Catholic Cem.**May 1, 1928**John J. Cowan & Son**401 Hollings*



E 33402 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33402

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Briscoe

2. FULL NAME Henry S. L. Bouchat

(a) RESIDENCE No. 1011 Briscoe

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ST., WARD

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)  
Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29, 1927

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

11

29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Md.

10 NAME OF FATHER William L. Bouchat

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary C. Langohr

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Chicago, Ill.14 Informant William L. Bouchat (Father)  
(Address) 1011 Briscoe St.15 PR 30 1928 JAMISON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 21, 1928, to April 27, 1928.  
that I last saw him alive on April 27, 1928  
and that death occurred, on the date stated above, at 10 p. m.  
The CAUSE OF DEATH\* was as follows:

Cald

(duration) yrs. mos. 5 ds.

CONTRIBUTORY  
(Secondary) Bertha Rucumond

(duration) yrs. mos. 7 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical ex  
(Signed) J. M. L. M. D.4728 1928 (Address) 3409 Calhoun Ave.  
\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MIGAL DATE OF BURIAL

London Park April 30 1928

20 UNDERTAKER

John F. Denny 715 Lytle

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33403

## CERTIFICATE OF DEATH.

E 33403

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 S. 6th St., Brooklyn ST. 25-75 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin E. Collison

(a) RESIDENCE NO. 126 S. 6th St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9, 1928

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 3 20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Harry M. Collison

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary E. Chenoweth

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)

14 Informant Harry M. Collison

(Address) 126 S. 6th Street

15 Filed 1928 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 19 28

17

I HEREBY CERTIFY, That I attended deceased from

Jan 9, 19 28, to April 25, 19 28,

that I last saw him alive on April 25, 19 28,

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Spine-Befida  
and Meningocele

(duration) yrs. mos. ds.

CONTRIBUTORY Exhaustion  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles A. Brown, M. D.

19 28 (Address) Brooklyn, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill

DATE OF BURIAL

5-1 1928

20 UNDERTAKER

John F. Denn

ADDRESS

715 Light

E 33404

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 7 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day,

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from Jan 10<sup>th</sup> 1928, to April 29 1928, that I saw him alive on April 29 1928, and that death occurred, on the date stated above, at 1230A.m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis &amp; mitral stenosis of heart.

## CONTRIBUTORY (Secondary)

(Signed) J. J. Strickland Jr. M. D.

April 30 1928 (Address) 632 Torrance

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL.

## 20-UNDERTAKER

## ADDRESS

Filed 1928 HAMMOND JONES, M. D.

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33405

## CERTIFICATE OF DEATH.

E 33405

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 723 Bond St. 7-4 Ward)2-FULL NAME Paul Adamski(a) RESIDENCE NO. 723 Bond St. 7-4 Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) June 26-277 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
10 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

## 9 BIRTHPLACE (city or town) \_\_\_\_\_

(State or country) Mo10 NAME OF FATHER St. Adams11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Poland12 MAIDEN NAME OF MOTHER Mary Paul13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) Poland

## 14

Informant Mary Adams  
(Address) 723 Bond

## 15 Filed

1928 HAMPSON JONES, M. D.  
RECEIVED Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28 192817 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia  
(duration) 1 yrs. 1 mos. 1 ds.

## CONTRIBUTORY (Secondary)

at 24/25 G. C. Glades 7-4 14376 Bway  
(Signed) (Coroner) (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Rosary4/30 1928

## 20 UNDERTAKER

ADDRESS

Wm. F. Adams 1618 6 Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33406

## CERTIFICATE OF DEATH

90 E 33406

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2135 Bolton St. 13-5 Ward)2-FULL NAME Jesse A. Hann(a) RESIDENCE NO. Hamptstead Md St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. \_\_\_\_\_ ds. \_\_\_\_\_(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced (write the word)

MaleWhiteSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 22-1887

7 AGE

Years

Months

Days

IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min..

41—7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hamptstead  
Maryland

10 NAME OF FATHER

Francis L. Hann

11 BIRTHPLACE OF FATHER (City or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Gary Prior

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant

(Address)

Francis L. Hann  
Hamptstead Md

15 Filed

C. 19

HAMPSON JONES, M. D.

Registrar

REGISTERED NO.

13-5

St. \_\_\_\_\_ Ward \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29th 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 13th 1928, to April 29th 1928, that I last saw him alive on April 29th 1928, and that death occurred, on the date stated above, at \_\_\_\_\_

The CAUSE OF DEATH\* was as follows:

Cardiac decompensation

CONTRIBUTORY

(Secondary)

(duration)

yrs. 5

mos. \_\_\_\_\_

da. \_\_\_\_\_

Nephritis

(duration)

yrs. \_\_\_\_\_

mos. 10

da. \_\_\_\_\_

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Clinical & Physical

(Signed)

. 19

(Address)

William Messick, M. D.1700 Linden Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Hamptstead MdMay 2 1928

20 UNDERTAKER

Edw. Tipton

ADDRESS

Hamptstead Md

very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33407

E 33407

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *207 S Castle* St. *2-4* Ward)2-FULL NAME *Peter Cornelius Ruil*(a) RESIDENCE NO. *207 S Castle* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? *30* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of *Alice Ruil (Gise)*  
(or WIFE of \_\_\_\_\_)6 DATE OF BIRTH (month, day, and year) *June 18 1877*7 AGE Years *50* Months *10* Days *10* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Boatman*(b) General nature of industry, business, or establishment in which employed (or employer) *U. S. Coast Guard*

(c) Name of employer \_\_\_\_\_

## 9 BIRTHPLACE (city or town) \_\_\_\_\_

(State or country) *Holland*10 NAME OF FATHER *Unknown*

## 11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_

(State or country) *Holland*12 MAIDEN NAME OF MOTHER *Unknown*

## 13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_

(State or country) *Holland*

## 14

Informant *Alice Ruil*  
(Address) *207 S. Castle St.*

## 15 Filed \_\_\_\_\_

19 *HAMPSON JONES* M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 28 1928*17 I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquiry*  
(Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said *Inquiry* and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Myocardial Stenosis*

## CONTRIBUTORY (Secondary)

*Cardiac Asthenia*  
*appr 28/28*  
*28/28*  
*143 No Bway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mt. Carmel Cemetery* 5/1 1928

## 20 UNDERTAKER

*John G. Connelly* ADDRESS *Every*

Very important. See instructions on back of certificate.

E 33408

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33408

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1008 Rutland* ST., *7-13* WARD)2-FULL NAME *Mildred Kennedy*(a) RESIDENCE NO. *1008 Rutland* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**col.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 12, 1927*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*7**16*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto*10 NAME OF FATHER *James Kennedy*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto*12 MAIDEN NAME OF MOTHER *Helen Reed*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto*

14

Informant *Helen Reed*

(Address)

APR 30 1928

15

Filed

PR 30 1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 28, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Apr 20, 1928*, to *Apr 28, 1928*.that I last saw her alive on *Apr. 28, 1928* and that death occurred, on the date stated above, at *10:25 A.M.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *measles*

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chin. Exam.*(Signed) *A. M. Jones*

19

(Address) *1056 Edmonstone*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

*Laurel Cem.*  
*Mrs. J. G. Locke*

ADDRESS

*Apr. 30 1928*  
*302 Jefferson*

E 33409

# Melvin J. Cone. HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33409

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 E ChurchST. 22-33 WARD)

## 2-FULL NAME

Frank Court Melvin J. Cone(a) RESIDENCE NO. 219 E Church

(Usual place of abode)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Cigars Case

6 DATE OF BIRTH (month, day, and year)

June 6 1865

7 AGE

Years

Months

Days

If LESS than 1 day, his or min.

621023

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Furniture oil

(b) General nature of industry, business, or establishment in which employed (or employer)

Worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

not known

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

not known

14

Informant (Address)

Cigars Case 219 E Church St

15

Filed

30 1928C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 28 4, 1928 to April 29 4, 1928

that I last saw him alive on

April 29 4, 1928and that death occurred, on the date stated above, at 12:40 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Liver

do not know (duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

H. C. Conner

M. D.

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Cross A.C.C.5-12 1928

FUNERAL ADDRESS

ADDRESS

Est. Hader 115 E West St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33410  
1—PLACE OF DEATHCITY OF BALTIMORE: (No. 107 W. Saratoga ST., 4-23 WARD)2—FULL NAME Martha M. Benson(a) RESIDENCE NO. 107 W. Saratoga ST., 4-23 WARDLength of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 0 yrs. 0 mos. 0 ds.

REGISTERED NO.

E 33410

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX FA 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Widowed6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Benson6 DATE OF BIRTH (month, day, and year) Sept 7, 18507 AGE Years 77 Months 4 Days 22 If LESS than 1 day, 0 hrs. 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) England  
(State or country)10 NAME OF FATHER Thomas Smith11 BIRTHPLACE OF FATHER (city or town) England  
(State or country)12 MAIDEN NAME OF MOTHER Martha Hildering13 BIRTHPLACE OF MOTHER (city or town) England  
(State or country)Informant Mand. Mag. Spiden  
(Address) 107 W. Saratoga St.Filed 1928 19 HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29, 192817 I HEREBY CERTIFY, that I attended deceased from April 24 to April 29, 19 28that I last saw him alive on April 29, 19 28and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH\* was as follows:

ApoplexyArterio-sclerosis, nephritis,Myocarditis (duration) 4 yrs. 0 mos. 0 ds.(Secondary) (duration) 4 yrs. 0 mos. 0 ds.18 Where was disease contracted ✓

if not at place of death?

Did an operation precede death? no Date of ✓Was there an autopsy? no

What test confirmed diagnosis?

(Signature) Ronald T. Petersen, M. D.4/29, 1928 (Address) 184 Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL WoodlawnDATE OF BURIAL May 1 19 28ADDRESS 507 E. North Ave.20 UNDERTAKER W. M. Conh

E 33411

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33411

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

University Hospital

ST.

WARD)

## 2. FULL NAME

Lillie Saunders

(a) RESIDENCE NO.

128 N. Chapel

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

black

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1908

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

South Carolina

10 NAME OF FATHER

Hamilton Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country)

S. C.

12 MAIDEN NAME OF MOTHER

Emma Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

S. C.

14

Informant (Address)

Waring, Hug, Peck, &amp; Co.

15

30 1928

HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 29 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 16, 1928, to Apr. 29, 1928,

that I last saw him alive on Apr. 29, 1928,

and that death occurred, on the date stated above, at 4:45 A. M.

The CAUSE OF DEATH\* was as follows:

Bilateral Salpingitis

(duration)

yrs.

mos. 21

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 7

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

yes

Date of Apr. 20, 1928

Was there an autopsy?

yes

What test confirmed diagnosis?

Operation &amp; clinical findings

(Signed)

H. V. Stetson, M. D.

19

(Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Bury Cemetery

May 3 1928

20 UNDERTAKER

ADDRESS

Edward Bryson

address

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33412

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1521 N. Appleton Ward 5-21)2-FULL NAME Alex Freeman(a) RESIDENCE NO. 1521 N. Appleton Ward 5-21Length of residence in city or town where death occurred 16 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? 16 yrs. mos. ds.REGISTERED NO. E 33412

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Freeman6 DATE OF BIRTH (month, day and year) 18647 AGE Years 64 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia  
(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Chas. Freeman  
(State or country) Russia12 MAIDEN NAME OF MOTHER Fagie13 BIRTHPLACE OF MOTHER (city or town) Russia  
(State or country)14 Informant Ida Freeman  
(Address) 1521 N. Appleton15 Filed 1925 11/10/25 ONE M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1925I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis  
(duration) 6 yrs. 6 mos. — ds.

## CONTRIBUTORY (Secondary)

(duration) 6 yrs. 6 mos. — ds.  
(Signed) Edw. Lewis M. D. (Coroner)  
(Address) Coroner

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death!

Former or usual residence.....

18 PLACE OF BURIAL, CREMATION OR REMOVAL Neheem Rosedale Date of Burial 4/30/2520 UNDERTAKER Joeh LewisADDRESS 1439 E. Bay





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33414

## CERTIFICATE OF DEATH

E 33414

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 45 W. West St., 23-21 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 45 W. West St. 23 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. (If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 Color or Race

Col.

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Benson Cunningham

6 DATE OF BIRTH (month, day, and year)

march - 1898

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

N. C.

10 NAME OF FATHER

Harris Gilmore

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Cecilia Sellers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

N. C.

14

Informant  
(Address)

J. H. Jones

15 Filed

C. HANSON Jones, M.

PR 30 1928

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/28 1928

17

I HEREBY CERTIFY, That I attended deceased from  
4/12/28, to 4/28/28,  
that I last saw him alive on 4/27/28.

and that death occurred, on the date stated above, at 12:05 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

CONTRIBUTORY

(Secondary)

Recurrent Bronchitis  
(Influenza type)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Jones, M. D.

(Address) 908 Sharp St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Baltimore, Md. 4/30/28

20 UNDERTAKER

ADDRESS

Samuel M. M. M.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33415

## CERTIFICATE OF DEATH.

E 33415

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3637 Elm Ave. ST. 13-52 WARD)

2. FULL NAME Selina M. Williams.

(a) RESIDENCE No. 3637 Elm Ave

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)  
married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Robert F. Williams

6 DATE OF BIRTH (month, day, and year) May 22, 1865

7 AGE

Years

Months 11

Days 6

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Va

10 NAME OF FATHER

John Edrington

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

12 MAIDEN NAME OF MOTHER

Sophia Withers

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Va

14

Informant  
(Address)

Robert F. Williams

15

Filed

0 1928

G. HAMPSON JONES, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 28, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
4-20 1928 to 4-28 1928  
that I last saw her alive on 4-28 1928

and that death occurred, on the date stated above, at 645 P.M.

The CAUSE OF DEATH\* was as follows:

Diabetic Coma.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Thyroid eyes

(Signed)

C. F. Hughes

Address

3701 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Woodlawn

DATE OF BURIAL

May 1, 1928

20 UNDERTAKER

Chenoweth &amp; Son Chestnut

E 33416

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33416

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *W S Marine Hospital #43-57* ST. *WARD*)2-FULL NAME *Melvin S Ford*(a) RESIDENCE No. *38 46 Duanyane*  
(Usual place of abode)Length of residence in city or town where death occurred *28* yrs. *8* mos.ST. *WARD*(If non-resident give city or town and State)  
yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced  
HUSBAND of *Ron Ford*  
or WIFE of6 DATE OF BIRTH (month, day, and year) *Aug 6, 1899*7 AGE Years *28* Months *8* Days *23* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *not known*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md*  
(State or country)10 NAME OF FATHER *Amos Ford*11 BIRTHPLACE OF FATHER (city or town) *Baltimore Md*  
(State or country)12 MAIDEN NAME OF MOTHER *Edith Turner*13 BIRTHPLACE OF MOTHER (city or town) *West. Va*  
(State or country)14 Informant *Edna L. Simmons*  
(Address) *5320 Melrose Park*15 Filed *1928* 19 *C. HAMPSON JOHNS, M.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/29/28*17 I HEREBY CERTIFY, That I attended deceased from *4/26/28*, 19 to *4/29/28*, 19 that I last saw him alive on *4/29/28*, 19 and that death occurred, on the date stated above, at *10:40 P* m.

The CAUSE OF DEATH\* was as follows:

*Uremia**4 days* (duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *arterial hypertension* (duration) *not known* ds.18 Where was disease contracted if not at place of death? *not known*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Phys Exam & Laboratory*(Signed) *J. A. Sullivan* M. D.19 (Address) *W. S. Marine Hospital*

\*State the Disease Causing Death, or in deaths from Violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 33417

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33417

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *16-75* Ward)2-FULL NAME *Baby Boy Campbell*(a) Residence No. *1213 Fairfield Rd*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S. if of foreign birth?

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE.

*White*

5-Single.

Married,  
Widowed,  
or Divorced,  
(Write the word.)5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of6-DATE OF BIRTH (month, day and year) *4/29/28*

7-AGE.

If LESS than 1 day,  
..... hrs. or 25 min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work.....(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)  
(State or Country),*Baltimore, Md.*10-NAME OF  
FATHER*Samuel Martin Campbell*11-BIRTHPLACE  
OF FATHER (city or town),*York, Pa.*12-MAIDEN NAME  
OF MOTHER*Juella May Smith*13-BIRTHPLACE  
OF MOTHER (city or town),*Brooklynville, Md.*

14-

(Informant) *Hospital Records*  
(Address) *Luxemburg & Avenue*

15-

Filed

*30 1828*

192

*HAMPSON JONES*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *4/29/28*17- I HEREBY CERTIFY, That I attended deceased from  
*4/29* 1928 to *4/29* 1928  
that I last saw him alive on *4/29* 1928  
and that death occurred, on the date stated above, at *4* P. M.

The CAUSE OF DEATH\* was as follows:

*Prematurity*  
*Congenital Atelectasis*CONTRIBUTORY  
(Secondary)

(Duration)..... yrs. mos. ds.

18-Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date of .....Was there an autopsy? *no*What test confirmed diagnosis? *Physical signs*(Signed) *Thos H Reynolds* M. D.(Address) *University Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes  
state (1) Means and Nature of Injury, and (2) whether Accidental  
Suicidal, or Homicidal. (See reverse side for additional space)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL

DATE OF BURIAL.

20-UNDERTAKER.

ADDRESS

*Suters Balto Co**April 30 28**Chenoweth & Son 3617 Chestnut Ave*



*Hopwood.* ✓  
HEALTH DEPARTMENT—CITY OF BALTIMORE **E 33418**

**E 33418**

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1000 W 40th St-52* WARD)2. FULL NAME *Charles W. Hopwood*(a) RESIDENCE NO. *1000 W 40th St*

(Usual place of abode)

Length of residence in city or town where death occurred *2 1/2* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male. White**Married*5a If married, widowed, or divorced HUSBAND of or WIFE of *Emma Hopwood*6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

*58*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Turner*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ind*10 NAME OF FATHER *Fred Hopwood*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Ind*12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Unknown*

14

Informant (Address) *H. W. Hopwood*

15

Filed

19

HENDERSON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 29 1928*

17

I HEREBY CERTIFY That I attended deceased from *Apr 20 1928* to *Apr 24 1928*That last saw him alive on *Apr 24 1928*and that death occurred, on the date stated above, at *1045A*

The CAUSE OF DEATH\* was as follows:

*Cerebral Pressure*CONTRIBUTORY (Secondary) *Arterio Sclerosis* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *C. F. Hughes* D. 4-30-28 (Address) *3701 R. d. 11*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

*Int. Alivet**May 2 1928*

20 UNDERTAKER

ADDRESS

*Chenoweth Son*

33419

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33419

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *10-69* WARD)2-FULL NAME *Edua Emelie Hinkelman*(a) RESIDENCE NO. *2526 Boyd St*  
(Usual place of abode)Length of residence in city or town where death occurred *2* yrs. *0* mos. *0* ds.ST. *10-69* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*5 Single, Married, Widowed, Divorced (write the word)  
*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct 22, 1925*

7 AGE

Years *2*Months *7*Days *9*If LESS than  
1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Penna*10 NAME OF FATHER *Henry Hinkelman*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Anna Wingloka*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *Henry Hinkelman*  
*2526 Boyd St*

15

Filed *3/7/1928*, 19 *28*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 30 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 9*, 19*28*, to *April 30*, 19*28*, that I last saw her alive on *April 30*, 19*28*, and that death occurred, on the date stated above, at *12:11 a. m.*  
The CAUSE OF DEATH\* was as follows:*Laryngeal Diphtheria*CONTRIBUTORY (Secondary) *Bronchopneumonia* (duration) yrs. mos. *22* ds.18 Where was disease contracted if not at place of death? *Home* (duration) yrs. mos. *16* ds.Did an operation precede death? *Substituted* Date of *Apr. 9, 1928*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical pos. culture*(Signed) *Myron G. Dull*, M. D.\*30. 19*28* (Address) *Sydenham Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
*Western Crem*

DATE OF BURIAL

20 UNDERTAKER

*Robert Brooks & Son*

ADDRESS

*Adrian Hall*

E 33420

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1031 Greenmount Ave St. 10-14 Ward)

Registered No. 100-33420

2-FULL NAME Shirley Guiler

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1031 Greenmount Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-Single, 2

Married,  
Widowed,  
or Divorced,  
(Write the word.)5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 4-17-1928

7-AGE,

yrs. mos. 12 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town), Baltimore, Md.  
(State or Country),10-NAME OF  
FATHER, Charles Guiler11-BIRTHPLACE  
OF FATHER (city or town), Wheeling  
(State or Country), W. Va.12-MAIDEN NAME  
OF MOTHER, Lillian Colvin13-BIRTHPLACE  
OF MOTHER (city or town), Clarkstown  
(State or Country), W. Va.

14-

(Informant).....

(Address).....

15-

Filed

C. HAMPSON JONES, M. D.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 4-29-28

17- I HEREBY CERTIFY, That I attended deceased from  
4-29-1928 to 4-29-1928.

that I last saw her alive on Head in arrival, 19

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia.

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary) Respiratory Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted  
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Histology, Gram, &amp; sputum.

(Signed) Wm. J. Sullivan M. D.

19 (Address) 32 C. Hamilton St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19-PLACE OF BURIAL, CREMATION OR DATE OF BURIAL,  
REMOVAL

20-UNDERTAKER.

C. HAMPSON JONES, M. D.  
Registrar.

ADDRESS

APR 30 1928

E 33421

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33421

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

St. Agnes Hospital 4th WARD

## 2-FULL NAME

Charles Spruck.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

711 W. Fayette St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or .... min.

64

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Md

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

Mrs. Emma Spruck  
711 W. Fayette St., City

## 15

Filed

19

Registrar

9398

THE MORGUE

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from

4-24-1928, to April 27, 1928.

that I last saw him alive on April 27, 1928

and that death occurred, on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical  
Signed: J. H. Jones, M.D.  
Address: 1911 W. Fayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

Comm. Health.

ADDRESS

APR 30 1928



Thomas Love  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33422

## CERTIFICATE OF DEATH.

33422

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

BALTIMORE CITY HOSPITAL

## 2-FULL NAME

Thomas Love

## (a) RESIDENCE No.

BALTIMORE CITY HOSPITALS

(Usual place of abode)

Length of residence in city or town where death occurred

55 yrs.

mos.

ds.

ST.

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sealover

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

## 10 NAME OF FATHER

?

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

?

## 12 MAIDEN NAME OF MOTHER

?

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

?

## 14

Informant (Address)

Rebecca

## 15

Filed

30-1928 C. HAMPSON JONES, M. D.

Registrar

26-37

ST. WARD

ST. WARD

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

4/30/1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Dec. 21, 1925, to Apr. 30, 1928

that I last saw him alive on Apr. 30, 1928

and that death occurred, on the date stated above, at 8:10 A. M.

The CAUSE OF DEATH\* was as follows:

Acute myocardial infarction  
myocarditis, chronic  
angina pectoris

(duration) 3 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

?

Did an operation precede death? ho Date of

Was there an autopsy? ho

What test confirmed diagnosis? General &amp; Sub

(Signed) C. Hampson Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

19

## ADDRESS

## 20 UNDERTAKER

Commissioner of Health

APR 30 1928

*Edward Harris*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33423

## CERTIFICATE OF DEATH.

43 E 33423  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST., 11-24 WARD)2-FULL NAME Edward Harris

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1040-10 Howard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5-9 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) ?5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?7 AGE Years 59 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salvage(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER John Harris11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.12 MAIDEN NAME OF MOTHER Emma ?13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.14 Informant (Address) BALTIMORE CITY HOSPITAL Records15 Filed 1928 2100 RAM Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26/192817 I HEREBY CERTIFY, That I attended deceased from Mar. 26, 1927 to Apr. 26, 1928 that I last saw him alive on Apr. 26, 1928 and that death occurred, on the date stated above, at 5:00 A. M.

The CAUSE OF DEATH\* was as follows:

Succession of myocardial  
to general metastases(duration) yrs. 6 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? ? if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General + Sub(Signed) C. Holmes Boyd, M. D.  
, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health.19  
APR 30 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33424

E 33424

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Jenkins Memorial Hospital

REGISTERED NO.

City of BALTIMORE: (No.

1000 Caton Ave St. 12-14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Keyser

(a) RESIDENCE NO.

1907 Barclay

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

about 72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Md.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Jenkins Memorial Hospital  
1000 Caton Ave Baltimore

15 Filed

19

C. HAMPTON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 17, 1928, to April 29, 1928.

that I last saw her alive on April 28, 1928.

and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

Chronic Myocarditis

(duration)

yrs.

mos.

da.

(duration)

yrs.

mos.

da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Francis H. Sudary, M. D.

, 19

(Address)

Dr. Agnes Hays

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mary M. Niedeck

7 1928

20 UNDERTAKER

Holy Redeemer Co.

ADDRESS

507 E 22 St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33425

## CERTIFICATE OF DEATH.

E 33425

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 50 S Fulton Ave ST. 19-28 WARD)2-FULL NAME Patience Lee(a) RESIDENCE NO. 50 S Fulton Ave

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 18667 AGE Years 61 Months 6 Days 13 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)10 NAME OF FATHER Thomas Lee11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Mary Lee13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant John Lee (Address) 50 S Fulton Ave15 1928 C. HAMPSON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28 192817 I HEREBY CERTIFY, That I attended deceased from Apr 27 1928, to Apr 28 1928, that I last saw him alive on Apr 27 1928, and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH\* was as follows:

Acute Corbionic PhlebotomyCONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physician's(signed) James L. Thompson M.D. 4/29/28 (Address) 1729 N. Fulton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Cathedral Cem

DATE OF BURIAL

5/1/28

20 UNDERTAKER

George A. Farley Fulton & Fayette

See instructions on back of certificates



E 33426

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33426

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL*)ST. *7-9* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John Burton*(a) RESIDENCE NO. *Chesapeake Ave*

(Usual place of abode)

ST. *York Rd* WARD *Town*Length of residence in city or town where death occurred yrs. mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *7-3-28*7 AGE Years Months Days *27* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md -*10 NAME OF FATHER *John Burton*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md -*12 MAIDEN NAME OF MOTHER *Lula Sneyd*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Id -*14 Informant (Address) *Records -*15 *C. HAMPSON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 30, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 28, 1928* to *April 30, 1928*.that I last saw him alive on *April 30, 1928*.and that death occurred, on the date stated above, at *3 20 A* m.

The CAUSE OF DEATH\* was as follows:

*Diffuse broncho pneumonia, following measles.*(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

*Glandular spots* (duration) yrs. mos. *3* ds.18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*J. Bernier* M. D. (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Prospect Hill Cem**May, 1928*

20 UNDERTAKER

ADDRESS

*John Burns Sons**Towson*

E 33427

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33427

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 W. Lombard ST. 18-76 WARD)

2-FULL NAME Vernon Robert Thompson

(a) RESIDENCE NO. 1218 W. Lombard St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7<sup>th</sup> 1928

7 AGE	Years	Months	Days 22	If LESS than 1 day,.....hrs. or.....min.
		2		

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER William J. Thompson

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Marie Osh

13 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) Baltimore, Md.

14 Informant Mr. Thompson  
(Address) 1218 N. Lombard St.

15  
Filed *19* **HAMPSON JONES** *M. H.*  
*Reed* Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) April 29, 1928

17 I HEREBY CERTIFY, That I attended deceased from  
April 14th, 1928, to April 29th, 1928

The CAUSE OF DEATH\* was as follows:

Whooping Cough	15 Days
Malnutrition	

(duration) ..... yrs. .... mon ..... ds.

CONTRIBUTORY Cardiac Asthenia  
(Secondary)

(duration) ... yrs. .... mos. 1 da

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?.....Date of

### Was there an autopsy?

**What test confirmed diagnosis?**

(Signed) Edw. H. L. L., M. D.

30, 1928 (Address) 24 N. Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

## UNDERTAKER

ADDRESS \_\_\_\_\_

ADDRE  
The Fields 200 N Lombard

E 33428

James Field Dunn

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33428

CERTIFICATE OF DEATH.

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4100 Roland Ave

ST. 13-52 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Field Dunn

(a) RESIDENCE NO. 4100 Roland Ave

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 76 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? 76 yrs. 8 mos. 1 ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah H. Dunn

6 DATE OF BIRTH (month, day, and year) Aug-27-1951

7 AGE Years Months Days 76 8 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President of Addison & Dunn Inc. (b) General nature of industry, business, or establishment in which employed (or employer) Self (c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Andrew H. Dunn

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Conelia Andrew

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

PARENTS

14 Informant Howard T. Dunn (son) (Address) 3913 Hawthorne Ave.

15 0 1928 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1928

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1928, to April 29, 1928, that I last saw him alive on April 28, 1928, and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH\* was as follows: Cerebral Hemorrhage (Hemiplegia)

CONTRIBUTORY (Secondary) Arterio-sclerosis (duration) yrs. 1 mos. 14 ds. Unknown duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical (Signed) William P. Hall M. D. 19 (Address) 4715 on a Raintown Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge Cemetery

20 UNDERTAKER STEWART & MOWEN COMPANY (William F. WOODEN, Successor)

ADDRESS

103 W. NORTH AVE

E 33429

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33429

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 E. Euter ST. 5-8 WARD) 129

## 2. FULL NAME

Rosa Papa

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

431 N. Euter ST.

## WARD

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female white

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Vincenzo Papa

## 6 DATE OF BIRTH (month, day, and year)

Feb 15 1867

## 7 AGE

61 Years2 Months13 Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Italy

## 10 NAME OF FATHER

Joseph G. Gappi

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

## 12 MAIDEN NAME OF MOTHER

Antonia

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

## 14

## Informant

Frances Gappi

## (Address)

419 N. Euter

## 15

## File

19 HAMPSON JONES, M. D.

## Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28 1928

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927, to Apr 28, 1928, that I last saw her alive on Apr 28, 1928, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George S. S. Stephens M. D. Address 1407 N. Euter

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Italy Redeemer Church Feb 30 1928

## UNDERTAKER

George F. Rutt 1735 1/2 Bayford Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33430

## CERTIFICATE OF DEATH.

E 33430

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2100 Sunkland Rd. Ward 15-60)2-FULL NAME Walter F. Merrifield(a) RESIDENCE NO. 2100 Sunkland Rd. Ward 15-60

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 7 mos. 27 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Sept 1-1884

7 AGE

Years

Months

Days

43729

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore10 NAME OF FATHER Wm F. Merrifield11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Maine12 MAIDEN NAME OF MOTHER Carrie B. Rich13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Maine

14

Informant  
(Address)Carrie B. Merrifield  
2100 Sunkland Rd.

15

FILED

1928  
C. HAMPSON JONES, M. D.  
Regist

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29 1928

17

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signature) F. C. Smith M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lindem Park Cemetery

20 UNDERTAKER

W. H. Huppert 1850 W. Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33431

## CERTIFICATE OF DEATH

REGISTERED NO.

33431

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

St.

Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town)

(State or country)

14

Informant (Address)

15

Date

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

Apr 13, 1928, to Apr 22, 1928,

that I last saw him alive on Apr 27, 1928,

and that death occurred, on the date stated above, at 8:55 P. M.

The CAUSE OF DEATH\* was as follows:

Intestinal Obstruction  
Splenoma

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

Berenger Harris M. D.  
38 S. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33432

E 33432

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 W. Lexington St. ST. 19-27 WARD)

## 2. FULL NAME

Jeter Franklin Ball

## (a) RESIDENCE No.

1518 W. Lexington St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

25. Unknown ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Negro

## 5 Single, Married, Widowed, or Divorced, (write the word)

Wid.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Rachel Ball

## 6 DATE OF BIRTH (month, day, and year)

Nov. 29, 1882

## 7 AGE

Years  
45Months  
4Days  
0If LESS than  
1 day, hrs  
or, min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Constuction

(c) Name of employer

Unemployed

## 9 BIRTHPLACE (city or town) (State or country)

Northumberland Co. Va.

## 10 NAME OF FATHER

Jermiah Ball

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Northumberland Co. Va.

## 12 MAIDEN NAME OF MOTHER

Sarah Tolson

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Northumberland Co. Va.

## 14

Informant  
(Address)Jermiah Ball Jr.  
1518 W. Lexington St.

## 15

Filed

30-1928

19

HAMPSON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) April 29th 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 27, 1928 to April 29th 1928that I last saw him alive on April 28 h. 1928  
and that death occurred, on the date stated above, at 6 45 p.m.

The CAUSE OF DEATH\* was as follows:

Mitral decompensation

Mitrx Ch. Interstitial Neph.

CONTRIBUTORY  
(Secondary)(duration) ? yrs. 2 mos ? ds.  
Congestion of Lungs18 Where was disease contracted  
if not at place of death?(duration) yrs. mos. 4 ds.  
At place of death

Did an operation precede death?

NO

Date of

Was there an autopsy?

NO.

What test confirmed diagnosis? Physical Exam.

(Signed)

Walter J. Jackson

M. D.

, 19

(Address) 1631 W. Franklin St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

W. A. Ballou

4/30/28

ADDRESS

916  
De al

E 33433

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33433

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 4-125 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Gray(a) RESIDENCE NO. 245 Pearl st.

(Usual place of abode)

ST. 4-125 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39				

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Maryland10 NAME OF FATHER Thomas Gray11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore  
Maryland12 MAIDEN NAME OF MOTHER Ella Johnson13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Hospital Records  
(Address)15 Filed 1928 S. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 192817 I HEREBY CERTIFY, That I attended deceased from  
April 18, 1928, to April 26, 1928,that I last saw him alive on April 26, 1928,and that death occurred, on the date stated above, at 10.20 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis  
(duration) 12 yrs. 10 mos. 0 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) S. E. Madden, M. D.4-26-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOV. Mount Auburn Ave4/30 1928

20 UNDERTAKER

ADDRESS 916  
Dr. Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33434

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *626 E. Eager* ST. *10-15* WARD)2—FULL NAME *Bella Maikel*(a) RESIDENCE NO. *626 E. Eager* ST.,

(Usual place of abode)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *George H Maikel*6 DATE OF BIRTH (month, day, and year) *Jan 8 1875*7 AGE Years *53* Months *3* Days *22* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balt Md*10 NAME OF FATHER *McIntosh*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balt Md*12 MAIDEN NAME OF MOTHER *Maria Elliott*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balt Md*Informant *George H Maikel* (Address) *626 E Eager St*Filed *1928* 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 30 1928*17 I HEREBY CERTIFY, That I attended deceased from *Apr 4*, 19*28*, to *Apr 29*, 19*28*, that I last saw him alive on *Apr 29*, 19*28*, and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH\* was as follows:

*Ch myocorditis*CONTRIBUTORY (Secondary) *Ch nephritis* (duration) yrs. *2* mos. ds.(duration) yrs. *2* mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physicist*(Signed) *G. H. Hornstern*, M. D.*430*, 19*28* (Address) *733 Argonne St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 33435

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33435

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* 12-51

WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

12 yrs.

mos.

ds.

ST.

WARD

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

widowed

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Dora P Greene

6 DATE OF BIRTH (month, day, and year)

Oct 22-1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78

6

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Balto, Md

10 NAME OF FATHER

Green, Mrs G.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary McVey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant

(Address)

Byron D Greene  
The S Pratt St. (Greenland)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-30 1928

17

I HEREBY CERTIFY, That I attended deceased from

4-23-28, 19 to 4-30, 1928.

that I last saw him alive on

4-30, 1928.

and that death occurred, on the date stated above, at

6:12 a.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of the floor of mouth &amp; general metastasis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

unknown

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

J.B. Deane, M.D.

, 19 (Address)

University Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

William Cook

ADDRESS

502 E. N. Ave.

E 33436

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33436

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 605 N. Calvert St. 11-7 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.St. 11-7 Ward(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

12-10-52IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Artist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)Henry Hesse  
3502 Lanny Rd.

16

Filed

C. HAMPTON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 27-192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Valv. disease heart

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

ah 50 (Signed) W. H. H. H. M. D.  
(Coroner), 1928 (Address) 1644 Bury

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Marys Hampton Date of Burial 5/2 1928

20 UNDERTAKEN

Wm Cooks ADDRESS 5026 North ave

Very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33437

## CERTIFICATE OF DEATH.

31 E 33437

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 814 Ashland Ave

St. 10-14 Ward)

## 2-FULL NAME

Louis L. Brown

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 814 Ashland Ave

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 Color or Race

C

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Jennie Brown

## 6 DATE OF BIRTH (month, day, and year)

1886

## 7 AGE

Years

Months

Days

42

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer (Common)

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

S. Carolina

## 10 NAME OF FATHER

Benj. Brown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

S.C.

## 12 MAIDEN NAME OF MOTHER

Elizabeth

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

S.C.

## 14

Informant

(Address)

Wife Jennie Brown

814 Ashland Ave  
C. HAMPSON JONES, M. D.

## 15

Filed

1928

Per

Attest

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928  
Apr 29/28

## 17

I HEREBY CERTIFY That I took charge of the

remains described above, held an

inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry

And that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

M. D.

4/30/28 Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs. ....mos. ....ds.

In the

State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Asbury Cem.

5/2/1928

## 20 UNDERTAKER

ADDRESS

Jost. Rochester

Jefferson

Very Important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33438

## CERTIFICATE OF DEATH.

90 E 33438

## 1-PLACE OF DEATH

City of BALTIMORE: (S. No.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johann Berg

6 DATE OF BIRTH (month, day, and year) Sept 17 1870

7 AGE Years 57 Months 7 Days 11 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

## 15 Filed

C. HAMPSON JONES, M. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27 1928

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest, autopsy or inquiry.

hereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows

Nutrat Stenosis

## CONTRIBUTORY

18 (duration) yrs. mos. ds. 19 (Address) 143 W Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

E 33439

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33439

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Belts General Hospital*)

## 2. FULL NAME

*Lilley Holley*(a) RESIDENCE NO. *1112*  
(Usual place of abode)Length of residence in city or town where death occurred *10* yrs. mos. ds.

ST., WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 4, 1896*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *31*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*  
(State or country)10 NAME OF FATHER *Joseph Holley*11 BIRTHPLACE OF FATHER (city or town) *Rt. Mary Co. Md.*  
(State or country)12 MAIDEN NAME OF MOTHER *Hedrieth Boll*13 BIRTHPLACE OF MOTHER (city or town) *Rt. Mary Co. Md.*  
(State or country)14 Informant *Southern Holley*  
(Address) *1112 Lawrence St.*15 Filed *1928* *C. HAMPSON JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 28, 1928*17 I HEREBY CERTIFY, That I attended deceased from *March 22, 1928* to *April 28, 1928*, that I last saw her alive on *April 28, 1928* and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular Heart Disease*  
*Chronic Pelvic Inflammatory disease*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Myocardial Failure*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *Yes* Date of *4/28/28*Was there an autopsy? *No*What test confirmed diagnosis? *Clin. Exam*(Signed) *Louis T. Jones*, M. D.(Address) *W. Belts General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*West Auburn Cemetery* *May 1 - 1928*

UNDERTAKER

ADDRESS

*Thomas E. Kelson* *1303 Princeton St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33440

E 33440

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 Ramsay ST. 14-28 WARD)2-FULL NAME Margaret M. Collins(a) RESIDENCE NO. 1515 Ramsay St ST. 14-28 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (Write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Collins6 DATE OF BIRTH (month, day, and year) July 29/19027 AGE Years 25 Months 9 Days 29 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) at home(c) Name of employer self9 BIRTHPLACE (city or town) Balto Md. (State or country)10 NAME OF FATHER John P. Spearman11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)12 MAIDEN NAME OF MOTHER Mary Zimmach13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)14 Informant M. William H. Collins (Address) 1515 Ramsay St15 C. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28 192817 I HEREBY CERTIFY, That I attended deceased from Jun 25, 1926, to Apr 28, 1928, that I last saw her alive on Apr 28, 1928, and that death occurred, on the date stated above, at 2:25 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary P. B.(duration) 2 yrs. 8 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 409 S. Park StDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? nausea test(Signed) H. E. Knipp M. D.(Address) 4025 Edmondson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL Rudow Park Cemetery DATE OF BURIAL May 1 192820 UNDERTAKER Harry H. Witzke ADDRESS 1531 N. Lombard St.

E 33441

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33441

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

2-FULL NAME

(a) RESIDENCE NO. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Married

5a If married, widowed, or divorced  
HUSBAND of  
(last name of)

Melvin Forney

6 DATE OF BIRTH (month, day, and year)

Dec 28, 1893

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

35

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mechanician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Ind

10 NAME OF FATHER

James Forney

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Mass

12 MAIDEN NAME OF MOTHER

Linn

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ind

14

Informant  
(Address)

Wm. Blauvelt

15

Filed

19

HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21 1928

17

I HEREBY CERTIFY, That I attended deceased from 4/27, 1928, to 4/28, 1928,

that I last saw him alive on 4/28, 1928,

and that death occurred, on the date stated above, at 10:40 P. M.

The CAUSE OF DEATH\* was as follows:

Sudden Coronary  
Thrombosis  
PregnancyCONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical Exam

(Signed)

J. M. Gray, M. D.

438, 1928 (Address)

Baltimore, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

May 2, 1928

20 UNDERTAKER

Harry H. Hitzke

ADDRESS

1531 7th  
Farmingdale





212787  
E 33443

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 131 E 33443

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

JOHNS HOPKINS HOSPITAL

## 2-FULL NAME

Eduin C. Hill

ST.

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2370 S-W-17<sup>th</sup>

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST.

WARD

Miami - Fla.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

6 4 11 89

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

2

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Chicago Ill.

10 NAME OF FATHER

Wm Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Eng -

12 MAIDEN NAME OF MOTHER

Martha Bayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Wis -

14

Informant (Address)

Records -

15

Filed

G. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1928

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1928, to April 30, 1928, that I last saw him alive on April 30, 1928, and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH\* was as follows:

Pyelonephritis, left.

CONTRIBUTORY (Secondary)

(duration)

3 yrs.

mos.

ds.

Bronchopneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Fla.

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy &amp; Clin. Tests.

(Signed)

, 19

(Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Miami Fla.

DATE OF BURIAL

4/30/28

20 UNDERTAKER

Hughes &amp; Jones Inc

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33444

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital

ST. 25-75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Brittingham

(a) RESIDENCE No. 213 N. 1st St., Brooklyn, Md. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widower

5a If married, widowed, or divorced HUSBAND of or WIFE of not known

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1876

7 AGE Years 51 Months 7 Days 2 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mate

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer Schr. "Robert"

9 BIRTHPLACE (city or town) Virginia (State or country)

10 NAME OF FATHER Sam Brittingham

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Sophronia Bean

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14

Informant Records, U.S. Marine Hospital (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 19 28

17 I HEREBY CERTIFY, That I attended deceased from April 10, 19 28, to April 29, 19 28,

that I last saw him alive on April 29, 19 28,

and that death occurred, on the date stated above, at 11.45 P.m.

The CAUSE OF DEATH\* was as follows:

Cirrhosis, liver, atrophic

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical examination

(Signed) J. C. Francis, M. D.

19 (Address) U.S. Marine Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Filed

1928 HAMPTON JONES, M. D. Registrar

Registrar

Franklin W. Seitz 709 W 33 St

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 33445

## CERTIFICATE OF DEATH.

38 E 33445

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Calvert & 33*)ST. *11-15* WARD)

2-FULL NAME

*Frank G. Maslin*

(a) RESIDENCE NO.

*1304 St Paul St*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 Single, Married, Widowed,  
or Divorced, (write the word)*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*May 15, 1876*

7 AGE

Years

Months

Days

If LESS than  
1 day,.....hrs.  
or.....min.*51**11**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*None*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*James N. Maslin*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*West Virginia*

12 MAIDEN NAME OF MOTHER

*Mary L. Newcome*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Maryland*

14

Informant  
(Address)*Robert Maslin*  
*1304 St Paul St*

15

Filed

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 30, 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*April 10, 1928*, to *April 30, 1928*.that I last saw him alive on *April 30, 1928*.and that death occurred, on the date stated above, at *2:30* p. m.

The CAUSE OF DEATH\* was as follows:

*Terminal Syphilis*  
*Acute Cardiac Dilatation*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Acute Cardiac Dilatation*  
*Terminal Syphilis*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

4/30/1928 (Address)

*Union Memorial Hosp*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Greenmount Cemetery**May 2, 1928*

20 UNDERTAKER

ADDRESS

*Henry Jenkins & Son Co**614 North*  
*Charles St*



Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33446

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 Myrtle Ave Ward 7-24)

2-FULL NAME Louis C. James

(a) RESIDENCE NO. 1209 Myrtle Ave St. 7-24 Ward 7-24

(Usual place of abode) Length of residence in city or town where death occurred 58 yrs. 3 mos. 3 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race W.C. 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married James

6 DATE OF BIRTH (month, day, and year) Jan 26-18 70

7 AGE Years 58 Months 3 Days 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Porter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Chas. James

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Henrietta Pinkney

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant (Address) Margaret Wright 1209 Myrtle Ave

15 Filed 1928 G. HAMMOND JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured Skull

CONTRIBUTORY (duration) any hour President fell down cellar steps on head

(Signed) John L. Lusk M. D. (Address) Coroner

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Marcel Cem Date of Burial Apr 5-1928

20 UNDERTAKER Sam H. Chase & Son ADDRESS 1400 Market

33447

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33447

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 726 Dolphin

2-FULL NAME Catherine Gilles Russell

(a) RESIDENCE. No. 726 Dolphin

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fm

4 COLOR OR RACE

Col

5 Single, Married, Widowed,  
or Divorced (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Hezekiah Russell

6 DATE OF BIRTH (month, day, and year) DEC 20-1872

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

55

4

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

House wife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Ellicott City  
Md

10 NAME OF FATHER Rev. Levi Gilles

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

12 MAIDEN NAME OF MOTHER Eliza J. Fisher

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

14 Informant Hezekiah Russell  
(Address) 726 Dolphin15 Filed 1-1928 C. HAMMON JONES, M.  
Registral

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

ST.

WARD.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1928

17 I HEREBY CERTIFY, That I attended deceased from  
Dec 5, 1927, to April 29, 1928,

that I last saw her alive on April 29, 1928,

and that death occurred, on the date stated above, at 1:40 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (duration) yrs. mos. ds.

Intestinal Obstruction

18 Where was disease contracted  
(duration) yrs. mos. ds.

19 Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pharynx X-Ray

(Signed) Wm H. Wright M. D.

Address 1209 Presbiterian

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Cemetery

DATE OF BURIAL

20 UNDERTAKER

Sam N. Chase &amp; Son

ADDRESS

1400 N. Chesapeake

E 33448

King  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33448

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Hawthorne Road

ST. 27-53 WARD)

## 2-FULL NAME

Norval Herbert King

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## a) RESIDENCE No.

118 Hawthorne Road

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

51

yrs.

10

mos.

19

ds.

How long in U. S., if of foreign birth?

yrs.

10

mos.

19

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Helen Doshne King

## 6 DATE OF BIRTH (month, day, and year)

June-12-1976

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

10

19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Register of Wills

(c) Name of employer

City of Baltimore

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

Maryland

## 10 NAME OF FATHER

Calvin J. King

## 11 BIRTHPLACE OF FATHER (city or town)

Carroll Co.

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Mollie Goodbrink

## 13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Maryland

## 14

Informant Mrs. Helen B. King (wife)

(Address)

118 Hawthorne Road

## 15

Filed

19

C. HANSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 1 19 28

## 17

I HEREBY CERTIFY, That I attended deceased from

Dec 1, 1926

to

May 1, 19 28

that I last saw him alive on

April 30

19 28

and that death occurred, on the date stated above, at

5-a m.

The CAUSE OF DEATH\* was as follows:

Pulm. Tuberculosis  
nephritis. acute

(duration) 1 yrs. 6 mos. ds.

## CONTRIBUTORY (Secondary)

anemia

(duration) yrs. mos. 10 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? 2w Date of

Was there an autopsy? 2w

What test confirmed diagnosis?

(Signed)

Chas F. Blake

M. D.

May 1, 19 28 (Address)

20 E Preston

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mt. Olivet Cemetery

May-3-28 19

## 20 UNDERTAKER

## ADDRESS

STEWART &amp; MOWEN COMPANY

108 W. NORTH AVE.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33449

## CERTIFICATE OF DEATH

E 33449

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *4-7* Ward)2-FULL NAME *Sr. Mary Joseph Fenwick*(a) RESIDENCE NO. *Mercy Hosp.* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *62* yrs. *6* mos. *17* ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Oct. 12, 1865*7 AGE Years *62* Months *6* Days *17* IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *St. Marys Co* (State or country) *Maryland*10 NAME OF FATHER *Aloysius Fenwick*11 BIRTHPLACE OF FATHER (City or town) *md* (State or country)12 MAIDEN NAME OF MOTHER *Charlotte Falding*13 BIRTHPLACE OF MOTHER (city or town) *md* (State or country)14 Informant *Sister M. Maria* (Address) *Mercy Hospital*15 Filed *1928* C. 19 *HAMERSON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 29, 1928* 1817 I HEREBY CERTIFY, That I attended deceased from *April 26, 1928*, to *April 29, 1928*, that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_.and that death occurred, on the date stated above, at *5:10* p.m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*CONTRIBUTORY (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Secondary) *Pulmonary edema*(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *2* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. Sheldon Eastland*, M. D.. 19 (Address) *2736 N. Calvert St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*St. Agnes Mt Washington**May 19 28*

20 UNDERTAKER

ADDRESS

*Henry H. Jenkins & Son Co**2000 Orchard St*

very important. See instructions on back of certificates. Exact statement of OCCUPATION is



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33450

## CERTIFICATE OF DEATH.

90 E 33450

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 606 W. Redwood St., 4-30 Ward)2-FULL NAME W. L. Walters alias Harry Walters(a) RESIDENCE NO. 606 W. Redwood St., 4-30 Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Unknown5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Melvia Stein6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years 67 Months — Days — IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER Thomas Walters11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Esther Criswell13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)14 Informant Helping Up Mission  
(Address) 606 W. Redwood St.15 Filed 1928 HAMMON JONES, M. D.  
R. H. C. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probable  
Myocardial insufficiency  
(duration) — yrs. — mos. — ds.CONTRIBUTORY  
(Secondary)(duration) — yrs. — mos. — ds.  
(Signed) Agnes Zell & M. D.  
(Coroner)(Address) 2739 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edgar Hill Date of Burial 5/2 192820 UNDERTAKER J. J. Haggins ADDRESS 138 N. E. St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 33451

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33451

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 S. Hull

ST. 24 WARD

2-FULL NAME Stanislaus Wlatkowski

(a) RESIDENCE NO. 1112 S. Hull

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

infant

6 DATE OF BIRTH (month, day, and year)

May 1, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, 1 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Maryland

10 NAME OF FATHER

Adam Wlatkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Francis Witkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant

Adam Wlatkowski

(Address) 1112 Hull St.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 1 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1928, to May 1, 1928.

that I last saw him alive on May 1, 1928.

and that death occurred, on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH\* was as follows:

Strophysia neonatorum.

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Premature birth (8 months)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Henry F. Buettner

M. D.

, 19

(Address)

1319 Light St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Holy Rosary May.

1

1928

UNDERTAKER

ADDRESS

J. W. Gazeurki

1930

Eastern Ave

MAY 1 - 1928

C. HAMPSON JONES

For

Record

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33452

## CERTIFICATE OF DEATH

E 33452

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N Chester St. ST. 6-10 WARD)

## 2—FULL NAME

Bessie Rosenstein

## (a) RESIDENCE NO.

103 N Chester St.

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth 44 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harris Rosenstein6 DATE OF BIRTH (month, day, and year) 18757 AGE Years 50 Months — Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia10 NAME OF FATHER Jehuda Lach11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia14 Informant Harris Rosenstein (Address) 103 N Chester St.15 Filed C. H. HAYDON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1/2817 I HEREBY CERTIFY, That I attended deceased from 9/10, 1926, to 5/1, 1928,that I last saw him alive on 5/1, 1928, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris(duration) 1 yrs. — mos. — ds.CONTRIBUTORY (Secondary) Hyper tension(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Jones, M. D.5/1, 1928 (Address) 103 N Chester St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Friendship Cem

DATE OF BURIAL

5/1/28

20 UNDERTAKER

Jack Lewis 1439 E. 1st St.

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33453

## CERTIFICATE OF DEATH.

90 E 33453

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 N. Bond

ST. 7-13 WARD)

2-FULL NAME Annie Brooks

(a) RESIDENCE NO. 815 N. Bond

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

(or) WIFE of

William B. Brooks

6 DATE OF BIRTH (month, day, and year) home - 1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

5

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Henrico Co Va.

10 NAME OF FATHER

Hennis Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Lucy Browne

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

Sister Peter Thelton 1533 E. Madison St

15

Filed

1928

C. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 27 1928 to April 29 1928

that I last saw her alive on April 29 1928

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) 1 yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary)

Chronic Myocarditis

(duration) 1 yrs. 5 mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Baltimore Md

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

None Physical exam

(Signed)

Calvin B. Le Compte, M. D.

, 19

(Address) 814 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Richmond Va

UNDERTAKER

May 2 1928

ADDRESS

Robert Williams 1515 W. Eldon St



E 33454

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33454

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Pennington St. WARD 5)2—FULL NAME Katherine Kutchera(a) RESIDENCE NO. 721 Pennington St.(Usual place of abode)  
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.  
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed6 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Charles Kutchera6 DATE OF BIRTH (month, day, and year) Apr. 16, 18867 AGE Years 41 Months 4 Days 13 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Europe10 NAME OF FATHER Joe. Kerchman11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Mrs. John Plummer  
(Address) 721 Pennington St.15 Filed 1-1928 C. HAMPSON JONES  
Per H. Jones

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28/2817 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1928, to Apr 28, 1928.that I last saw her alive on Apr 25, 1928, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma OesophagusCONTRIBUTORY (Secondary) Guil Debility (duration) Unknown yrs. mos. ds.18 Where was disease contracted if not at place of death? Unknown (duration) Unknown yrs. mos. ds.Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? X-raySigned John B. Norton, M. D.  
307, 1928 (Address) Curtis Bay, B. Ads.

\*State the Disease Causing Death, or in deaths from Violent state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Hill Cemetery20 UNDERTAKER Margaret L. Plummer

DATE OF BURIAL

May 19 28

ADDRESS

E 33455

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33455

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3029 St. Paul St.

ST. 17-50 WARD)

## 2. FULL NAME

Mary Claire Schofield Leishear.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

3029 St. Paul St.

ST.

WARD

(Usual place of abode)

Lifetime

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Thomas Leishear

## 6 DATE OF BIRTH (month, day, and year)

August 9th. 1870

## 7 AGE

Years

Months

Days

If LESS than  
1 day... hrs.  
or min.

57

8

21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... At. Home

(b) General nature of industry, business, or establishment in which employed (or employed)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

## 10 NAME OF FATHER

Henry Schofield

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

## 14

Informant

Mrs. Dandy.

(Address)

3029 St. Paul St.

## 15

Filed

19

HAMPSON JONES, M. D.

Registrar

## 16 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30th, 1928.

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1927, to April 30, 1928.

that I last saw him alive on April 29, 1928.

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma

(duration) 1 yr. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goodbarrow, M. D.

, 19 (Address) 2923 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery.

DATE OF BURIAL

May 2, 1928.

20 UNDERTAKER

ADDRESS

Chas. R. Goodbarrow 1181 Mt Royal Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33456

33456

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 *Andre* St. ST. 24-35 WARD)

2-FULL NAME John Burdynski

(a) RESIDENCE No. 1428 *Andre* St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1885

7 AGE Years Months Days If LESS than 1 day, hrs or min.  
42 9 4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Labor

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER Luis Burdynski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER Mary Mackowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant Stanislaw Burdynski (Address) 1428 *Andre* St.

15

FILED 1928 19 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 19 28

17

I HEREBY CERTIFY, That I attended deceased from

April 24, 19 28, to April 29, 19 28.

that I last saw him alive on April 29, 19 28.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Influenza (5 days)  
Pulmonary Pneumonia  
Acute Edema (Pulmonary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. E. Jones, M. D.

1928 (Address) 2020 Harbor Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Rosary May 2 19 28

20 UNDERTAKER

ADDRESS

John M. Weber 401 1/2 Chester St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33457

## CERTIFICATE OF DEATH

817 Park Ave  
90 E 33457

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 48 Roland Court ST., 53 WARD)2—FULL NAME Julia P. Gueding(a) RESIDENCE NO. 48 Roland Court ST.,

(Usual place of abode)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs.  mos.  ds. How long in U. S., if foreign birth?  yrs.  mos.  ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed6a If married, widowed, or divorced Widowed  
(or) WIFE of Willis E. Gueding6 DATE OF BIRTH (month, day, and year) Jan-8-18607 AGE Years 68 Months 3 Days 28 If LESS than 1 day,  hrs. or  min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dayton  
(State or country) Ohio10 NAME OF FATHER Henry Fredericks11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Lein Kowre13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)

14

Informant Marian A. Proctor  
(Address) 48 Roland Court

15

Filed 1928 C. HAMPSON JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1-1928

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1928, to April 30th, 1928, that I last saw her alive on April 30th, 1928, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH\* was as follows:

Pericarditis with Effusion  
Pulmonary Edema(duration) 3 yrs. 3 mos. 3 ds.CONTRIBUTORY Chronic Myocarditis  
(Secondary) Ch. Valvular Heart Disease?  
(duration) 2 yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) H. V. Harper, M. D.19 (Address) 817 Park Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Freedom H. Cremation5/2 1928

20 UNDERTAKER

ADDRESS

Melvin Cook582 E. Knob



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33458

## CERTIFICATE OF DEATH

74-001 E 33458

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1270 Washington Blvd)

ST.

WARD)

## 2—FULL NAME Christina Michael

(a) RESIDENCE NO. 1270 Washington Blvd

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S. if foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John Michael

6 DATE OF BIRTH (month, day, and year) Jan. 10/1845

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

83

3

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

10 NAME OF FATHER John Rhinkhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant John H. Michael (Address) 9 Garrison Ave

15

Filed

19

HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1928

17

I HEREBY CERTIFY That I attended deceased from April 1, 1928, to April 30, 1928.

that I last saw him alive on 4/30/28, 19

and that death occurred, on the date stated above at 4 A. m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

CONTRIBUTORS (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. P. H. Adams

M. D.

19

(Address) 1727 20th Ave

\*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

J. M. Cook

577 E North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33459

## CERTIFICATE OF DEATH

E 33459

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 E Preston ST.,

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary H. Haller(a) RESIDENCE NO. 1208 E Preston ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE M5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced HUSBAND of (or) WIFE of Engene Haller6 DATE OF BIRTH (month, day, and year) Oct 6, 1849

7 AGE

Years 78Months 6Days 23

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va10 NAME OF FATHER Benjamin Haller11 BIRTHPLACE OF FATHER (city or town) (State or country) Va12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14

Informant H. C. Smith(Address) 3504 Dennison Rd

15

Filed 1928

19

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29, 1928

17

I HEREBY CERTIFY, That I attended deceased from

October, 1926, to April 29, 1928.that I last saw him alive on April 28, 1928and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Herbert Knapp, M. D.Apr 30, 1928 (Address) 1216 E. Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL GreenmountDATE OF BURIAL May 2, 192820 UNDERTAKER W. H. CookADDRESS 502 E. North Ave

# SPARHAWK

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33460

E 33460

## CERTIFICATE OF DEATH:

1-PLACE OF DEATH *Church Home & Infirmary* REGISTERED NO. *11*  
 CITY OF BALTIMORE: (No. *4916 Palmer Ave* ST. *21* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 2-FULL NAME *Dorothy Sparhawk*  
 (a) RESIDENCE NO. *4916 Palmer Ave* ST. *21* WARD  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred *5* yrs. *11* mos. *21* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*  
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_  
 6 DATE OF BIRTH (month, day, and year) *May 8<sup>th</sup> 1922*  
 7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*5 years 11 21*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *none*  
 (c) Name of employer *no*

9 BIRTHPLACE (city or town) *Baltimore*  
 (State or country) *Md*

10 NAME OF FATHER *Harry Edwin Sparhawk*  
 11 BIRTHPLACE OF FATHER (city or town) *Baltimore*  
 (State or country) *Md*  
 12 MAIDEN NAME OF MOTHER *Dorothy A. Hering*  
 13 BIRTHPLACE OF MOTHER (city or town) *Edwards Co. Md*  
 (State or country)

14 Informant *Harry Edwin Sparhawk*  
 (Address) *4916 Palmer Ave Baltimore*  
 15 Filed *1-1928* 19 *C. HAMMOND JONES* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/29 1928*

17 I HEREBY CERTIFY, That I attended deceased from *April 29* 1928, to *April 29* 1928, that I last saw her alive on *April 29* 1928, and that death occurred, on the date stated above, at *8 20 p.m.*

The CAUSE OF DEATH\* was as follows:

*Acute appendicitis*

(duration) yrs. mos. *7* ds.  
 CONTRIBUTORY *General peritonitis*  
 (Secondary) (duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_

Was there an autopsy? *yes*

What test confirmed diagnosis? *Physical signs, Necropsy, Cultures*  
 (Signed) *J. Frank Hewitt* M. D.

(Address) *Church Home & Infirmary*  
 \*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *London Park*

DATE OF BURIAL

*5/2/28*

20 UNDERTAKER

*Geo. Weber & Son 2503 E. Monument Ave*

This is very important. See instructions on back of certificates. Exact statement of death must be properly classified.

E 33461

HEALTH DEPARTMENT—CITY OF BALTIMORE E 33461

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 W. Lombard

ST.

2-FULL NAME William H. Reed

(a) RESIDENCE NO. 843 W. Lombard  
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Jennie Reed

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1854

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

74

3

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stationary

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Retired

9 BIRTHPLACE (city or town)  
(State or country)

Delaware

10 NAME OF FATHER

Peter Reed

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Delaware

12 MAIDEN NAME OF MOTHER Sarah Carter

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Delaware

14

Informant  
(Address)Mrs. Hannah V. Reed  
843 W. Lombard St.

15

Filed

1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Mar. 1, 1928, to Apr. 29, 1928.  
that I last saw him alive on Apr. 24, 1928,  
and that death occurred, on the date stated above, at 6 P. m.  
The CAUSE OF DEATH\* was as follows:

Acute Myocardial Infarction

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Channing St.

(Signed)

Channing St. M. D.

(Address) 838 W. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

St. Paul Cemetery, Kent Co.

May 2, 1928

20 UNDERTAKER

ADDRESS

1003 W.  
Baltimore St.



E 33462

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Seiling's Sanatorium

CITY OF BALTIMORE: (No. Pinecrest, Norwood Hts ST. 11-70 WARD)

2-FULL NAME Mary Lynch

(a) RESIDENCE No. 1303 Mt. Royal Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos.

ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE About 80 Years Months Days If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not obtainable

12 MAIDEN NAME OF MOTHER Not obtainable

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not obtainable

14 Informant Miss Julia McGurr (Address) 1303 Mt. Royal Ave.

15 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 19 28

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20, 19 28, to May 1, 19 28, that I last saw him alive on May 1, 19 28, and that death occurred, on the date stated above, at 9 PM.

The CAUSE OF DEATH\* was as follows:

Bere bone Arterio-sclerosis

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Plain case

(Signed) J. H. Harrison, M. D. 11, 19 28 (Address) 907 H. Chas.

\*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cemetery

May 3, 1928

20 UNDERTAKER

ADDRESS

Henry W. Means &amp; Son - 805 N. Calvert St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33463

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 9-17 St., 9-17 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 1629 N. Springs Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Krastel6 DATE OF BIRTH (month, day, and year) 18607 AGE Years 68 Months 70 Days 68 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Baltimore County Md

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

## 14

Informant (Address) Mrs. Margaret Krastel 1629 N. Springs

## 15

Filed 1928

C. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE

16 DATE OF DEATH (month, day, and year) April 29 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to this death on the day stated above.

The CAUSE OF DEATH\* was as follows:

4.7.2. Myocardial infarction  
lung abscess - acute 24 hours  
(duration) ..... yrs. .... mos. .... ds.  
4.7.2. Secondary  
lobar pneumonia  
(duration) ..... yrs. .... mos. .... ds.(Signed) W. J. Ruth

(Coroner)

Address 1039 Bury

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death for 10 yrs. .... mos. .... ds. In the State for 10 yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cemetery Date of Burial 5/2 1928

## 20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Harford Ave

PHYSICIANS should state CAUSE very important. See instructions on back of certificate. Exact statement of OCCUPATION is

E 33464

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33464

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rodger Bennett(a) RESIDENCE No. 413 S. Wright ST. 3-5 WARD 3-5

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteWidowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wattman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania10 NAME OF FATHER Rodger Bennett

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

New Jersey12 MAIDEN NAME OF MOTHER Mary Burton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

New Jersey

PARENTS

14

Informant

(Address)

Records

15

Filed

19

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 27, 1928, to Apr. 30, 1928that I last saw him live on Apr. 30, 1928and that death occurred, on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic parenchymatous hepatitis(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

General + Sub

(Signed)

C. St. Johnes Boyd, M. D.

, 19

(Address)

\*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

St. Carmel ChurchMay 2, 1928

20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Harford

E 33465

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33465

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *5713 St George Ave. Green*)2. FULL NAME *Francis J. Woods*(a) RESIDENCE NO. *5713 St George Ave. Green* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 *Single, Married, Widowed, or Divorced, (write the word)* *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary C Woods*6 DATE OF BIRTH (month, day, and year) *April 17 - 1951*7 AGE Years *77* Months *X* Days *10* LESS than 1 day... hrs. or... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*(b) General nature of industry, business, or establishment in which employed (or employer) *Sexton*(c) Name of employer *St Paul Church*9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Francis J. Woods*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Mary C. Woods*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*14 Informant *Mrs Mary C Woods* (Address) *5713 St George Ave Green*15 *1928* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-28 1928*17 I HEREBY CERTIFY, That I attended deceased from *4-22-1928*, to *4-28 1928*, that I last saw him alive on *4-27-1928* and that death occurred, on the date stated above, at *4-9-m*The CAUSE OF DEATH\* was as follows:  
*General arteriosclerosis with hypertension - Chronic Bright's - valvular heart disease, Hypostatic pneumonia* (duration) ? yrs. mos. ds.CONTRIBUTORY *acute myocarditis* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical* (Signed) *S. J. Smarce* M. D.(Address) *1604 Linden Ave*  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Holy Redeem Church* DATE OF BURIAL *May 2 1928*20 UNDERTAKER *George J. Ruth* ADDRESS *1735 Hayford Ave*



E 33466

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33466

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3801 Falls Road ST. 13-52 WARD)

2-FULL NAME Susan Cooper

(a) RESIDENCE NO. 3801 Falls Road ST., WARD

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph T. Cooper

6 DATE OF BIRTH (month, day, and year) Aug 11, 1842

7 AGE Years 85 Months 8 Days 18 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER Peter K. Baker

11 BIRTHPLACE OF FATHER (city or town) Penn. (State or country)

12 MAIDEN NAME OF MOTHER Mary Baker

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mr. George Cooper (Address) 3801 Falls Road

15 F. HAMMONS JONES, M. D. Registrar

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1928

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1927, to April 29, 1928, that I last saw him alive on April 29, 1928, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Cardiac Dilatation  
Apoplexy (Cerebral)  
(duration) yrs. mos. ds.CONTRIBUTORY Chronic Endocarditis  
(Secondary) Arterio Sclerosis  
(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. H. M. M. D.

, 19 (Address) 4032 Falls Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Middleton, Balto Co. Md.

May 3, 1928

20 UNDERTAKER

ADDRESS

E. Le Roy Steffen

125 F. North Ave

This is very important. See instructions on back of certificates.

E 33467

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33467

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3626 Fall Road*)2-FULL NAME *Doris Jean Heil*(a) RESIDENCE NO. *3626 Fall Road*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST., WARD

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 8 1926*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1 8 23*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto City*10 NAME OF FATHER *Henry Heil*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto City*12 MAIDEN NAME OF MOTHER *E. Catherine Little*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto City*

14

Informant (Address) *Henry Heil Jr.*

15

Filed *1928*

HAMPSON, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 1 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 8*, 19 *26*, to *May 1*, 19 *28*, that I last saw him alive on *May 1*, 19 *28*, and that death occurred, on the date stated above, at *11.45 a.m.* The CAUSE OF DEATH\* was as follows:*Cerebral Haemorrhage* (duration) *1* yrs. *8* mos *23* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Those of organized lot*(Signed) *Walter C. Bacon* M.D.5/1, 1928 (Address) *100 E 20th St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL *Druid Ridge*DATE OF BURIAL *May 2 1928*20 UNDERTAKER *A. S. Marshall*ADDRESS *3539 Fall Road*

Exact statement of OCCUPA-

See instructions on back of certificates.

E 33468

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33468

## CERTIFICATE OF DEATH

101-001 ✓  
5-8 REGISTERED NO.

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1253 E. Fayette ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

Rose Starks

## (a) RESIDENCE NO.

1253 E. Fayette ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 2 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1926

7 AGE Years 2 Months 3 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

## 10 NAME OF FATHER

George Starks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Southern

## 12 MAIDEN NAME OF MOTHER

Hannah Blackwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

## 14

Informant: Hannah Blackwell Starks (Address) 1253 E. Fayette

## 15

Filed: 1926 HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 29, 1928, to May 1, 1928

that I last saw him alive on May 1, 1928

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Solus Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Acute myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xp. Exp.

(Signed) W. L. Curry, M. D.

, 19 (Address) 1420 E. Chase

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Asbury cemetery

DATE OF BURIAL

May 2, 1928

20 UNDERTAKER

Edward Bryan

ADDRESS 1631

Orleans St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33469

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Rear 1705 E. Biddle St. 8-13 Ward)

## 2-FULL NAME

Lewis P. Walters

## (a) RESIDENCE NO.

Rear 1705 E. Biddle Stst. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 Color or Race

W

5 Single, Married, Widowed,  
or Divorced, (write the word)

Widower

## 6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Margaret C. Walters

## 6 DATE OF BIRTH (month, day, and year)

Mar 7/1857

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

71

1

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Upholsterer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

## 10 NAME OF FATHER

Arthur W. Walters

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant

Arthur M Walters

(Address)

1110 McDonough St

## 15

HAMPSON JONES, M.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30-28

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.

inquiry and that said deceased came to his death  
topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Broncho pneumonia

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

M. D.

5/2/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

George W Zirkler

May 3 1928  
1737 E Egan St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PHYSICIANS should state CAUSE



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33470

## CERTIFICATE OF DEATH.

E 33470

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 27 E. Church St.St. 27-33 Ward

## 2-FULL NAME

Lottie Jolly.(C)(a) RESIDENCE NO. 27 E. Church St.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female.

4 Color or Race

Colored5 Single, Married, Widowed,  
or Divorced, (write the word)Widow.6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDo not know.

6 DATE OF BIRTH (month, day, and year)

Do not know.

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.60

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....None.(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

Baltimore, Md.

10 NAME OF FATHER

Do not know.

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Do not know.

12 MAIDEN NAME OF MOTHER

Do not know.

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Do not know.

14

Informant

Bessie Barnes.(C)

(Address)

37 E. Church St.

15 Filed.....19

HAMILTON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 192817 I HEREBY CERTIFY That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry find that said deceased came to her death  
(Inquest, au-  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

6/1 1928

(Address)

1017 E. Charles St\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKED

ADDRESS

OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS  
VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

E 33471

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 h Washington ST., 7-13 WARD)

2-FULL NAME Melvonea Mank

(a) RESIDENCE NO. 915 h Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/4/1927

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 10 26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

10 NAME OF FATHER August Mank

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Eva Mank

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant August Mank (Address) 915 h Washington ST

15 Filed 1928 19 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-28

17 I HEREBY CERTIFY, That I attended deceased from 4-30-28 to 4-30-28, that I last saw him alive on 4-30-28, and that death occurred, on the date stated above, at 7:01 pm

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in summer

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? finding

(Signed) 5-2-28

Address 800 N. Calhoun St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Baltimore Cemetery 5/2 1928 George J. Ruth 1735 Harford Ave

THIS IS VERY IMPORTANT See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33472

## CERTIFICATE OF DEATH.

90 E 33472

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 10-14 WARD)2-FULL NAME Julius W. Cox(a) RESIDENCE NO. 1825 E. Madison ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleColoredDivorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

?

6 DATE OF BIRTH (month, day, and year)

?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Julius W. Cox

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Records

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 20, 1928, to Apr. 27, 1928that I last saw him live on Apr. 27, 1928and that death occurred, on the date stated above, at 6:00 A. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic & acutearteriosclerosisHypertension(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sub(Signed) C. Stelmus Boyd M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

19

D. Commissioner of Health

MAY 1 - 1928

See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH **E 33473**CITY OF BALTIMORE: (No. **4 West Lee** ST., **77-30** WARD)2-FULL NAME **Baby Bay Harding**(a) RESIDENCE No. **4 West Lee** ST., **77-30** WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Male** 4 COLOR OR RACE **White** 5 Single, Married, Widowed, or Divorced, (write the word) **Single**

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) **April 29, 1928**

7 AGE Years Months Days If LESS than 1 day 16 hrs. or 3 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) **4 West Lee ST** (State or country) **Baltimore Md**10 NAME OF FATHER **Luther Harding**11 BIRTHPLACE OF FATHER (city or town) **Rumkerton, N.C.** (State or country)12 MAIDEN NAME OF MOTHER **Hattie Ross**13 BIRTHPLACE OF MOTHER (city or town) **Trenton** (State or country) **New Jersey**14 Informant **Mrs. Luther Harding** (Address) **4 West Lee ST**15 **MAY 2 - 1928** **HAMPSON JONES, M.D.** Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **April 30 1928**17 I HEREBY CERTIFY, That I attended deceased from **April 29**, 1928, to **April 30**, 1928, that I last saw him alive on **April 30**, 1928,and that death occurred, on the date stated above, at **9 a** m.

The CAUSE OF DEATH\* was as follows:

**Prematurity**

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) **M. Alexander Jones** M. D., 19 (Address) **1516 Madison Ave**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

**JOHN HOPKINS HOSPITAL**

20 UNDERTAKER

**Commissioner Health**

ADDRESS

**MAY 1 1928**

This is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33474

## CERTIFICATE OF DEATH.

57 E 33474

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2808 Harlem Ave.* ST. *16-68* WARD)2-FULL NAME *Carolyn Ryan*(a) RESIDENCE NO. *2808 Harlem Ave.* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos.

ds.

How long in U. S., if of foreign birth? *4 1/2* yrs. - mos. - ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female white married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*John A. Riggs*6 DATE OF BIRTH (month, day, and year) *April 28-1962*7 AGE *66* Years

Months

Days

*2*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *John Gurrish*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Cathleen Gurrish*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Germany*

14

Informant (Address) *John A. Riggs 2808 Harlem Ave.*

15

Filed *May 1 1928*

W. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 1 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 25 1928 to May 1 1928*that I last saw him alive on *Mar. 29 1928*and that death occurred, on the date stated above, at *430 A. m.*

The CAUSE OF DEATH\* was as follows:

*Exhaustion*(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

*Diabetes*(duration) *12* yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *H. H. Robert Keach* M. D.(Address) *2502 Edgewater Ave. N.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Catholic Cemetery**May 4 1928*

20 UNDERTAKER

ADDRESS

*May A. Gauthier 2839 Rayner Ave*

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33475

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1210 Hanover St.* WARD *3-32*)2. FULL NAME *Emma C Hopkins*(a) RESIDENCE NO. *1609 Race St.* ST. *3* WARD *3*

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 17 1820*7 AGE *57* Years *11* Months *17* Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto* (State or country)10 NAME OF FATHER *Charles Bergerson*11 BIRTHPLACE OF FATHER (city or town) *Balto* (State or country)12 MOTHER'S NAME OF MOTHER *Emily Rger*13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country)14 Informant *Jessie Mortimer* (Address) *1210 Hanover St*15 Filed *1928* *HAMPSON JONES, M.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 30 19 28*17 I HEREBY CERTIFY, That I attended deceased from *Feb 20*, 19 *28*, to *April 30*, 19 *28* that I last saw him on *April 29*, 19 *28* and that death occurred, on the date stated above, at *5 A.* m. The CAUSE OF DEATH\* was as follows:*Cerebral Hemorrhage* (duration) yrs. *2* mos. *10* ds.CONTRIBUTORY (Secondary) *Exhaustion* (duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinically*(Signed) *J. B. Campbell, M.D.*4/30, 1928 (Address) *1644 Hanover St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St Olwet Cem.* DATE OF BURIAL *5/3 19 28*20 UNDERTAKER *J. M. Cully* ADDRESS *1210 Hanover St*

Exact statement of Q&amp;A - TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Exact statement of OCCUPA-  
TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 33476 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 33476  
CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 1208 Bank ST., 3-5 WARD)  
2-FULL NAME Domenico Migliorini  
(a) RESIDENCE NO. 1208 Bank ST., WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widowed  
5a If married, widowed, or divorced HUSBAND of Lucy Migliorini  
6 DATE OF BIRTH (month, day, and year) April 28, 1860  
7 AGE 68 Years 69 Months Days If LESS than 1 day, hrs or min.  
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Labor (b) General nature of industry, business, or establishment in which employed (or employer) 040 (c) Name of employer  
9 BIRTHPLACE (city or town) (State or country) Italy  
10 NAME OF FATHER Joseph Migliorini  
11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy  
12 MAIDEN NAME OF MOTHER unknown  
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Ursula De Angelis (Address) 916 E. Luzerne St.  
15 Filed 1928 19 HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 19 28  
17 I HEREBY CERTIFY, That I attended deceased from Apr 12, 19 28, to Apr 30, 19 28, that I last saw him alive on Apr 29, 19 28, and that death occurred, on the date stated above, at 4 a. m.  
The CAUSE OF DEATH\* was as follows:  
Bronchopneumonia  
(duration) yrs. mos. ds.  
CONTRIBUTORY Exhaustion (Secondary) (duration) yrs. mos. ds.  
18 Where was disease contracted if not at place of death?  
Did an operation precede death? Date of  
Was there an autopsy?  
What test confirmed diagnosis? signed) Luigi A. Di Stefano, M. D. Apr 30, 19 28 Address 1407 W. Euter St.  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)  
19 PLACE OF BURIAL, CREMATION OR RE-MOV. St Vincent's  
20 UNDERTAKER Wendell Phipps  
DATE OF BURIAL May 2, 19 28  
ADDRESS 300 S. Calver St.





E 33478

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

47 E 33478

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hosp 15-61*)2-FULL NAME *Mary Muller*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2403 Elsinor Ave.*

(Usual place of abode)

## WARD

Length of residence in city or town where death occurred *55* yrs. — mos. — ds.

(If non-resident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *white*5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of or) WIFE of *Herman Muller*6 DATE OF BIRTH (month, day, and year) *Sept 12, 1877*

## 7 AGE

Years *55*Months *7*Days *18*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *Edward Benjamin*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *Mary J. McCormick*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md*

## 14

Informant (Address) *Herman Muller 2403 Elsinor Ave.*

## 15

Filed *2-19-28*Registrar *W. W. Little*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 30, 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from *4-29*, 19 *28*, to *4-30*, 19 *28*,that I last saw her alive on *4-30*, 19 *28*,and that death occurred, on the date stated above, at *7<sup>30</sup> p.m.*

The CAUSE OF DEATH\* was as follows:

*Recurrent carcinoma of left breast*(duration) *1 1/2* yrs. mos. ds.CONTRIBUTORY (Secondary) *Melancholia to brain*(duration) *unknown* yrs. mos. ds.18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *yes* Date of *7-30-28*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *F. B. League*, M. D.19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL *London Park*

## DATE OF BURIAL

19 *28*20 UNDERTAKER *Geo W Little*

## ADDRESS

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33479

## CERTIFICATE OF DEATH

90 E 33479

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4015-Broadline Ave St. 13-54 Ward)2-FULL NAME Charles R. Becker

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 4015-Broadline Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 7 mos. 18 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Mary C. Becker (or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept. 12, 18527 AGE Years 70 Months 7 Days 18 IF LESS than 1 day hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Real EstateRetired 0459 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Henry Becker11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Sophia Orman13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany14 Informant Mrs. Mary C. Becker (Address) 4015-Broadline Ave15 Filed MAY 2 - 1928 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 192817 I HEREBY CERTIFY, That I attended deceased from Apr 30, 1928, to May 15, 1928.that I last saw him alive on Apr 30, 1928, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH\* was, as follows:

Acute Dilatation of HeartCONTRIBUTORY (Secondary) Chronic Myocarditis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Autopsy (Signed) A. C. S. Smith, M. D.(Address) 4509 Liberty Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Foundry Ave

Date of Burial

20 UNDERTAKER Mr. H. LillieADDRESS 100

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33480

## CERTIFICATE OF DEATH

101-001  
E 33480  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Prov. Hospital* St. *33* Ward)2-FULL NAME *Robert Irving*(a) RESIDENCE NO. *909 Watson* St.  Ward 

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Colored**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *?* *1902*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..*26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Jamieson B. W. S.*

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Jamieson West India*12 MAIDEN NAME OF MOTHER *Frances Perry*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*West India*

14

Informant  
(Address)*Nellie Clark*  
*412 E. 1st St.*

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*4-28-28*

17

I HEREBY CERTIFY, That I attended deceased from

*4-19-28*, to *4-28-28*that I last saw him alive on *4-28-28*, 19*28*.and that death occurred, on the date stated above, at *7:00* P. m.

The CAUSE OF DEATH\* was as follows:

*Codine Failure*(duration) yrs. mos. *1* da.CONTRIBUTORY  
(Secondary)*Lobar pneumonia*(duration) yrs. mos. *9* da.

18 Where was disease contracted

If not at place of death? *909 Watson St.*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical signs Symptom*(Signed) *Ernest C. Miller*, M. D.19 (Address) *5001 Penna. Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*St. Auburn**5/4/1928*

20 UNDERTAKER

ADDRESS

*Mrs. S. K. Holland 1638 David Baltimore*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33481

## CERTIFICATE OF DEATH.

90 E 33481

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2038. North Ave. St. 17-19 Ward 1)2-FULL NAME Henry E. Chandler (or, Sam)(a) RESIDENCE NO. 2038. North Ave. St. 17-19 Ward 1

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

2 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Jeanette

6 DATE OF BIRTH (month, day, and year)

12-10-1894

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

33-43-

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Don't know

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

none I believe

9 BIRTHPLACE (city or town)

(State or country)

Del.

10 NAME OF FATHER

Harry Ham

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Del.

12 MAIDEN NAME OF MOTHER

Margt. McElroy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Del.

14

Informant (Address)

James E. Chandler  
20117. 6th Ave

15

Filed..... 19

G. H. HARRISON JONES, M. D.  
Regist.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 1 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....  
(Inquest, autopsy or inquiry)thereon and from the evidence obtained by said.....  
(Inquest, autopsy or inquiry.)  
and that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valv. disease heartDon't know

(duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

acute indigestion - 9 am

(duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

(Address)

1629 3rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

UNDERTAKER

ADDRESS

William Cook502 E North

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33482

## CERTIFICATE OF DEATH.

90 E 33482

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 W. List Ave.

ST. 27-41 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARTHA MARY REVIER

(a) RESIDENCE NO. 2804 W. List Ave.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Harry G. Revier

6 DATE OF BIRTH (month, day, and year) June 9, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	68	10	29	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)

10 NAME OF FATHER Louis Goetzke

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known  
(State or country)14 Informant Mrs. Tillie Hupfeld (Daughter)  
(Address) 2804 List Ave.

15 Filed 1924 G. HANSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1928, to April 30, 1928, that I last saw her alive on April 30, 1928, and that death occurred, on the date stated above, at 4.05 p. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis (Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Perouge, M. D.

5/1, 1928 (Address) 514 Drury Lane

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL  
Baltimore Cemetery

DATE OF BURIAL

May 3, 1928

## 20 UNDERTAKER

Henry Sander &amp; Sons, Inc.

ADDRESS  
BALTIMORE ST  
& BROADWAY.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 33483

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129

E 33483

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *10-14* WARD)2-FULL NAME *Theresa B. Gilroy (Theresa B. Gilroy)*(a) RESIDENCE NO. *1226 Holbrook*

(Usual place of abode)

Length of residence in city or town where death occurred *34* yrs. — mos. — ds.

ST. — WARD

(If non-resident, give city or town and State)

How long in U. S. If of foreign birth? *14* yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Mar 14*

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs or — min

*34*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*10 NAME OF FATHER *James T. Gilroy*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md*12 MAIDEN NAME OF MOTHER *Katherine Cain*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md*

14

Informant (Address) *Mr. McGee*

15

Filed

19

C. H. HAMPSON, JONES, M. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/1/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *5/1/28*, 19, to *5/1/28*, 19, that I last saw her alive on *5/1/28*, 19, and that death occurred, on the date stated above, at *5:25 P. m.*

The CAUSE OF DEATH\* was as follows:

*Uremia*

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) *cardiac decompensation*

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. Lawrence Zahner*, M. D. 1928 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*New Catholic Cemetery**May 4 1928**Henry Wood**1301 E. Egan*

TION is very important See instructions on back of certificates.



E 33485

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 E 33485

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sinai Hospital* ST. *14-20* WARD)2-FULL NAME *Isaac Wyner*(a) RESIDENCE NO. *2009 Bolton*

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

ds.

How long in U. S., if of foreign birth? *40* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**white**Married*

5a If married, widowed, or divorced

HUSBAND (or) WIFE

*Emma Wyner*6 DATE OF BIRTH (month, day, and year) *August*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*62*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Tailoring*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Retired*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Russia*

10 NAME OF FATHER

*Isaac Wyner*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Mr. Kohn*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Russia*

14

Informant

(Address)

*Emma Wyner*  
*2009 Bolton St*

Filed

MAY 2 1928

C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/1* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from

*4/12/1928* to *5/1/1928*that I last saw him alive on *5/1* 19 *28*and that death occurred, on the date stated above, at *7:00 P. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of lung with secondary bone formation.*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Cardiac failure & pulmonary edema*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Henry Ginsburg* M. D.19 28 Address) *Sinai Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA

*Hebrew Friendship Cen**5/2* 19 *28*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. 14th St*Exact statement of OCCUPA-  
TION is very important See instructions on back of certificates.



Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26-A Co.-200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33486

CERTIFICATE OF DEATH

E 33486

1-PLACE OF DEATH

City of BALTIMORE: (No. 1120 Barclay St.

2-FULL NAME Francis P. Tracey.

(a) RESIDENCE NO. 1120 Barclay St.

(Usual place of abode)

Length of residence in city or town where death occurred

St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

St. Ward (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary A. Tracey

6 DATE OF BIRTH (month, day, and year)

August 15th. 1877

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

50

8

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

W. M. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto. Md.

10 NAME OF FATHER

John V. Tracey

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Boston

12 MAIDEN NAME OF MOTHER Mary A. Quinn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

England

14

Informant

Mrs. Mary A. Tracey.

(Address)

1120 Barclay St.

15

Filed

1928

C. H. HARRISON

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 1st. 1928.

19

17

I HEREBY CERTIFY, That I attended deceased from

April 24. 1928, to April 1 - 1928 that I last saw him alive on April 30. 1928.

and that death occurred, on the date stated above, at 4

The CAUSE OF DEATH was as follows:

Coronary Thrombosis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed)

5/1/1928 (Address)

Ben J. Hayles, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery.

Date of Burial

May 4th. 1928

ADDRESS

20 UNDERTAKER

Charles F. Hawk 118 W. Mt. Royal Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33487

## CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Ag Hosp.*)

2-FULL NAME

(Residence in Baltimore: No. *Thos J. Atkinson*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

St.; yrs. .... mos. .... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*  
6-DATE OF BIRTH, *Dec. 17* 18*85*  
(Month) (Day) (Year)  
7-AGE, *70* 4 *14* ds.  
yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Retired*  
(b) General nature of industry, business, or establishment in which employed (or employer).

### 9-BIRTHPLACE, (State or Country).

*Maryland*  
10-NAME OF FATHER, *Thos J. Atkinson*  
11-BIRTHPLACE OF FATHER, (State or Country), *Maryland*  
12-MAIDEN NAME OF MOTHER, *M. C. Crea*  
13-BIRTHPLACE OF MOTHER, (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

*C. HAMPSON JONES, M.*

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 1* 192*8*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

(person and from the evidence obtained by said *Inquiry* and that said deceased came to death on the day stated above.)

The CAUSE OF DEATH\* was as follows:

*Acc. Burns (2nd Degree Burns) Shock*

### CONTRIBUTORY (Secondary)

*May 1 1928* (Address) *14376 Wray*

\*State the Disease Causing Death, or, in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

MAY 2 - 1928

PHYSICIANS SHOULD BE KEPT ADVISED OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33488

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3929 Greenmount Ave.* ST., *9-47* WARD)2. FULL NAME *Jennie Hume Terry*(a) RESIDENCE NO. *3929 Greenmount Ave.* ST., *9-47* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of or) WIFE of *George F. Terry*6 DATE OF BIRTH (month, day, and year) *May 8/1843*7 AGE Years *84* Months *11* Days *23* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *England*10 NAME OF FATHER *John Hume*11 BIRTHPLACE OF FATHER (city or town) (State or country) *England*12 MAIDEN NAME OF MOTHER *Margaret Pike*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *England*14 Informant *Grace F. Hume* (Address) *3929 Greenmount Ave.*15 Filed *May 2 - 1928* HAMPSON JONES, JR. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 1 - 1928*17 I HEREBY CERTIFY, That I attended deceased from *October 14 - 1920*, to *May 1 - 1928*, that I last saw her alive on *April 28 - 1928*, and that death occurred, on the date stated above, at *12:40 P.* m.

The CAUSE OF DEATH\* was as follows:

*Atrophic Cirrhosis of Liver*(duration) *unknown* yrs. mos. ds.CONTRIBUTORY (Secondary) *Hypertension*(duration) *unknown* yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *physical signs & symptoms*(Signed) *Chester P. Jones*, M. D.5-2-1928 (Address) *2532 Edmondson Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Woodlark Cemetery* DATE OF BURIAL *5/3/28*20 UNDERTAKER *Joe Syfer* ADDRESS *1600 N. North Ave.*

PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 33489

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33489

## 1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 726 N. Carey ST. 16-20 WARD)2—FULL NAME Baby Warren(a) RESIDENCE NO. 726 N. Carey ST. 16-20 WARD

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ( ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Apr. 30, 187 AGE Years Months Days If LESS than 1 day, hrs. or 2 min. 11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Baltimore (State or country) MD.10 NAME OF FATHER Walter Warren11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country) VA.12 MAIDEN NAME OF MOTHER Blanche Donnell13 BIRTHPLACE OF MOTHER (city or town) N.C. (State or country) N.C.14 Informant Mrs. [unclear] (Address) \_\_\_\_\_15 Filed 2405 C. HAMMOND JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 30, 1817 I HEREBY CERTIFY, That I attended deceased from Apr. 30, 1928, to Apr. 30, 1928.that I last saw h. alive on Apr. 30, 1928 and that death occurred, on the date stated above, at 9:17 A.M.The CAUSE OF DEATH\* was as follows: Premature BirthCONTRIBUTORY (Secondary) malnutrition (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_ (duration) yrs. mos. ds.

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Deep Exam. (Signed) W. D. Perry, M. D., 19 (Address) 1410 E. Chase

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Commissioner of Health

MAY 2-1928

Important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.



E 33490

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33490

## I. PLACE OF DEATH

CITY OF BALTIMORE: (No. *12 Poplar Ave. Overlea* ST., *42* WARD)2. FULL NAME *George M. Brown*(a) RESIDENCE NO. *12 Poplar Ave. Overlea* ST., \_\_\_\_\_ WARD \_\_\_\_\_(Usual place of abode)  
Length of residence in city or town where death occurred *50* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of*Helena L. Brown*6 DATE OF BIRTH (month, day, and year) *Jan. 16<sup>th</sup> 1860*

7 AGE

*68* Years*3* Months*16* DaysIf LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Canaan*  
(State or country) *Connecticut*10 NAME OF FATHER *Nelson M. Brown*11 BIRTHPLACE OF FATHER (city or town) *Salisbury*  
(State or country) *Connecticut*12 MAIDEN NAME OF MOTHER *Oliver Saunders*13 BIRTHPLACE OF MOTHER (city or town) *Unknown*  
(State or country) *Connecticut*

14

Informant *Helena L. Brown*  
(Address) *12 Poplar Ave. Overlea*

15

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 1<sup>st</sup> 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*April 26, 1928* to *May 1<sup>st</sup> 1928*,  
that I last saw him alive on *May 1<sup>st</sup> 1928*,  
and that death occurred, on the date stated above, at *8:45* m.  
The CAUSE OF DEATH\* was as follows:*Chronic Myocarditis*(duration) *5* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY (Secondary) *Myocardial Insufficiency*(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *7* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Physical exam*(Signed) *Edw. H. Benson*, M. D.5/2/28 (Address) *Overlea Ind.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Carwood Cemetery**May 4, 1928*

20 UNDERTAKER

ADDRESS

*Frederick L. ...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH is very important.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 33491

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33491

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

South Ball. Gen. Hospital

CITY OF BALTIMORE: (No.

1213 Light St

ST. 25-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Mrs Lina Marie Leach

(a) RESIDENCE NO.

1114 11th St Marrell Park

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

11

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Solomon Leach

6 DATE OF BIRTH (month, day, and year)

Dec 14, 1871

7 AGE

Years

Months

Days

37

4

2

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Mississippi

10 NAME OF FATHER

J. E. Banton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Dacon Georgia

12 MAIDEN NAME OF MOTHER

Martha Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Augusta Georgia

14

Informant (Address)

Solomon Leach 1114 11th St Baltimore

15

Filed

19

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 10, 1928, to May 2, 1928, that I last saw her alive on May 2, 1928, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Pneumococic meningitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 2-3 ds.

(duration)

yrs.

mos. 22 ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Spinal Puncture (Signed) Tubercle v. D. Wack M. D.

5/2, 1928 (Address) 1213 Light St. Balt. Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Interment London Park Cemetery

DATE OF BURIAL

5/4 1928

UNDERTAKER

William Cook

ADDRESS

502 E North

E 33492

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33492

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST., *8-16* WARD)2-FULL NAME *Snively Arthur Helm, Jr.*(a) RESIDENCE NO. *2305 E. Lafayette* ST., WARD(Usual place of abode)  
Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 2 1924*7 AGE Years *3* Months *8* Days *0 29* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Snively Arthur Helm, Sr.*11 BIRTHPLACE OF FATHER (city or town) *Penn.* (State or country)12 MAIDEN NAME OF MOTHER *Anna Butler*13 BIRTHPLACE OF MOTHER (city or town) *Virg.* (State or country)14 Informant *S. A. Helm, Sr.* (Address) *2305 E. Lafayette*15 Filed *1928* *19* *HAMPSON JONES, M.D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 1 - 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 12*, 1928, to *May 1*, 1928, that I last saw him alive on *May 1*, 1928, and that death occurred, on the date stated above, at *12 15 p.m.*

The CAUSE OF DEATH\* was as follows:

*Facial Erysipelas*CONTRIBUTORY (Secondary) *Bronchopneumonia* (duration) yrs. mos. *38* ds.(duration) yrs. mos. *6* ds.18 Where was disease contracted if not at place of death? *At home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *J. P. Levin*, M. D.5-2, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*Baltimore Cemetery**5/3 1928*

20 UNDERTAKER

ADDRESS

*William Cook**502 E. North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

E 33493

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. *4-30* ST. *East Port, Md.* WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filer

C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 4/24/28, 1928, to 5/2/28.

that I last saw him alive on 5/2/28, 1928, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Parotitis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/2/28

Was there an autopsy? No

What test confirmed diagnosis? Chemical &amp; Spectro

(Signed) L. C. Humphreys, M. D.

5/2, 1928 (Address) U. S. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



E 33494

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33494

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 W. Hamburg, ST. 21-31 WARD)

2. FULL NAME Conrad Oetzel

(a) RESIDENCE NO. 505 W. Hamburg, ST.

(Usual place of abode)  
Length of residence in city or town where death occurred 47 yrs.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Margaret Oetzel

6 DATE OF BIRTH (month, day, and year) June 28, 1861

7 AGE Years 66 Months 10 Days 2 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1928.

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1928, to April 30, 1928, that I last saw him alive on April 29th, 1928, and that death occurred, on the date stated above, at 5:25 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Intestinal Catarrh

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. D. Jones, M. D. (Address) 1504 E. Eager St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

May 3, 1928.

ADDRESS

20 UNDERTAKER

Mr. &amp; Mrs. John W. Deyfel &amp; Son 801 W. Fayette St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec. - 7-17-26 - A Co. - 200 Bks.

HEALTH DEPARTMENT - CITY OF BALTIMORE

E 33495

CERTIFICATE OF DEATH

47 E 33495

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3104 Beverly Road St. 27-43 Ward

2-FULL NAME Annie S. Pearce

(a) RESIDENCE NO. 3104 Beverly Road St. Ward

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Officer Thos. G. Pearce  
6 DATE OF BIRTH (month, day, and year) March 22 - 1875  
7 AGE Years 53 Months 1 Days 9 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work SA Home  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Henry Dickman

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Sporennus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Officer Thos. G. Pearce 3104 Beverly Road

15 Filed 2-19-28

19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1928

17 I HEREBY CERTIFY, That I attended deceased from April 29th 1928, to May 1st 1928, that I last saw him alive on May 1st 1928, and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows: Lobar Pneumonia

CONTRIBUTORY (duration) yrs. mos. 3 da. (Secondary) Carcinoma

(duration) 3 yrs. mos. da.

15 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 1st

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory (Signed) A. A. Sordy M. D.

5-1-1928 (Address) 4218 Harford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial 5/4 1928

20 UNDERTAKER William Cook ADDRESS 802 E North Ave

E 33496

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33496

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 8-13 WARD)2-FULL NAME Martha Gephardt(a) RESIDENCE No. 2024 E. Riddle ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?7 AGE Years Months Days If LESS than 1 day, hrs. or min. 66

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) out

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER Dennis Bell11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Margaret?13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant (Address) Baltimore City Hospital

15

Filed 1928

G. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/192817 I HEREBY CERTIFY, That I attended deceased from Mar. 30, 1928 to April 30, 1928that I last saw him alive on April 30, 1928 and that death occurred, on the date stated above, at 6:40 A.M.

The CAUSE OF DEATH\* was as follows:

Myocarditis chronica acuta  
arteriosclerosis  
hypertension(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? general & sub(Signed) C. J. Holmes, M.D.  
, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Cedar Hill Cemetery May 3, 1928

20 UNDERTAKER

ADDRESS

Mrs. C. Miller Son 2334 Jefferson St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death should be stated EXACTLY. PHYSICIANS should state PA-TION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Hks.

E 33497

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

✓  
44 E 33497

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 6-10 WARD)

2-FULL NAME Barbara Manner

(a) RESIDENCE NO. 236 N. Port

(Usual place of abode)

ST. 6-10 WARD

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of or WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years 73 Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) in England

10 NAME OF FATHER in England

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Records

15 Filed 1926 19 26 at 10 REGISTRAR

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28/1928

17 I HEREBY CERTIFY, That I attended deceased from Mar. 22, 1928 to Apr. 28, 1928

that I last saw her live on Apr. 28, 1928

and that death occurred, on the date stated above, at 4:30 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach

(duration) yrs. 4 mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General + Sal.

(Signed) C. J. Holmes M. D.

BALTIMORE CITY HOSPITAL 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Cem

May 3, 1928

20 UNDERTAKER

ADDRESS

Mrs C. Muller & Son 2334 Jeffery



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33498

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1822 H Dovers St. 19-28 Ward)2-FULL NAME Henry Holder(a) RESIDENCE NO. 1822 H Dovers St. 19-28 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 65 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMary C. Hoeder

6 DATE OF BIRTH (month, day, and year)

July 4, 1857

7 AGE

Years

Months

Days

70926IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.None(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Germany

## 10 NAME OF FATHER

Henry Hoeder

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Ann Croon

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## PARENTS

## 14

Informant

(Address)

John Hoeder  
1822 Dovers St

## 15 Filed

C. HAMPSON JONES, M. D.

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 193817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquest, autopsy or inquiry.)hereon and from the evidence obtained by said  
topsy or inquiry, and that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Suicide  
Hangman

(duration) yrs. mos. ds.

## CONTRIBUTORY

(See reverse side)

(duration) yrs. mos. ds.

Signed G. B. Clark M. D., 19 (Address) 1430 Bway\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Landon Park Date of Burial May 3 1938

## 20 UNDERTAKER

Harry H. Witzke ADDRESS 1531 W. Lombard

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33499

## CERTIFICATE OF DEATH.

202 E 33499

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 14-20 Ward)2-FULL NAME Elizabeth Watson Smith(a) RESIDENCE NO. 1702 Bolton St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. (If non-resident give city or town and State)How long in U. S., if of foreign birth? 77 yrs. ? mos. ? ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single6 DATE OF BIRTH (month, day, and year) About - 18577 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. About 77 - -

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) none  
(c) Name of employer none9 BIRTHPLACE (city or town) Alexandria  
(State or country) Virginia10 NAME OF FATHER Robt. W. Smith11 BIRTHPLACE OF FATHER (city or town) Alex.  
(State or country) Val.12 MAIDEN NAME OF MOTHER Ellen Wattle13 BIRTHPLACE OF MOTHER (city or town) Alex.  
(State or country) Val.14 Informant John W. Davies (Nephew)  
(Address) Catoonsville Md15 1928 19 CHAMBERLAIN JONES, R. D.  
RAH Registrar

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1928 192 817 I HEREBY CERTIFY, That I took charge of the remains described above, held an \_\_\_\_\_  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said \_\_\_\_\_  
(Inquest, au-

topsy or inquiry.) \_\_\_\_\_ and that said deceased came to \_\_\_\_\_ death

on the day stated above.

The CAUSE OF DEATH\* was as follows:  
Gradual after end of from traumaticAfter 8 days (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY \_\_\_\_\_  
(Secondary) \_\_\_\_\_

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.  
(Coroner)\_\_\_\_\_, 1928 (Address) 1437 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? Read's Store - Howard & Leary Ln St.Former or usual residence 1702 Bolton19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexandria Va. Date of Burial May 4 / 192820 UNDERTAKER Stewart Mowen ADDRESS Baltimore

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

33500

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

2427 Madison Ave

CITY OF BALTIMORE: (No.

ST.

2-FULL NAME

Mrs. Carrie Cartwright

(a) RESIDENCE No. (Usual place of abode)

2427 Madison Ave

ST.

WARD

Length of residence in city or town where death occurred

21 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

33500

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

?

6 DATE OF BIRTH (month, day, and year)

?

1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Mrs. Sarah Murphy 2427 Madison Ave

15

File

1928 C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-30-1928

17

I HEREBY CERTIFY, That I attended deceased from

2-18-1928, to 4-30-1928,

that I last saw him alive on 4-30-1928,

and that death occurred, on the date stated above, at 5:15 P. M.

The CAUSE OF DEATH\* was as follows:

Cardio-Vascular Renal Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? clinical

(Signed) W. B. Bulte, M. D.

19 (Address) 425 N. Carbon St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOV. Mt. Auburn

5/3/1928

UNDERTAKER

ADDRESS

Mrs. Geo. H. Colla of 1631 Daniel St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33501

E 33501

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1319 Madison St. 11-24 Ward)2-FULL NAME Stanley Holfield(a) RESIDENCE NO. 1319 Madison St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

C

5 Single, Married, Widowed, or Divorced, (write the word)

single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

about 4 known

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

10 NAME OF FATHER Roland Holfield

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

14

Informant  
(Address)John B. White  
1319 Madison

15

Filed.....

19

C. HAMPSON JONES, M.D.  
Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

5/2/28

17

I HEREBY CERTIFY, That I attended deceased from

April 19, 1928, to May 2, 1928,that I last saw him alive on May 10, 1928,and that death occurred, on the date stated above, at 3:40 p.m.

The CAUSE OF DEATH\* was as follows:

Whooping Cough(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 13 ds.CONTRIBUTORY  
(Secondary)Broncho-Pneumonia(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds.

18 Where was disease contracted

If not at place of death? no

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) Marcell E. Jones, M. D., 19 \_\_\_\_\_ (Address) 1319 Madison\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Mt. Auburn5/3/1928

20 UNDERTAKER

ADDRESS

Mrs. Geo. H. Holland 1631 Dan  
St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of OCCUPATION OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33502

## CERTIFICATE OF DEATH

101-001 ✓  
E 33502

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *So. Balto. Gen. Hospital* ST *24-35* WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

*Mary Rauscher*

## (a) RESIDENCE NO.

*1610 E. Clement ST.*

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*6a If married, widowed, or divorced (or) *Widow of* *Antone J. Rauscher*6 DATE OF BIRTH (month, day, and year) *Oct 16, 1878*7 AGE Years *49* Months *6* Days *13* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Austria*

10 NAME OF FATHER

*John Braunford*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Austria*

12 MAIDEN NAME OF MOTHER

*Hedwig Lobar*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Austria*

## 14

Informant

*Antone J. Rauscher*

(Address)

*1610 E. Clement St.*

## 15

Filed

*C. HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 29, 1928*

17

HEREBY CERTIFY, That I attended deceased from *April 27*, 19 *28* to *April 29*, 19 *28* that I last saw him alive on *April 29*, 19 *28*and that death occurred, on the date stated above, at *11 P. M.*

The CAUSE OF DEATH\* was as follows:

*Coronary Atherosclerosis*

CONTRIBUTORY (Secondary)

*Lobar pneumonia* (duration) yrs. mos. ds. *2* *0* *0*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*J. F. Hawley* M. D.

19 (Address)

*1 G. Randall St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Holy Cross Cemetery*

DATE OF BURIAL

*May 3 1928*

20 UNDERTAKER

*Margaret J. Flynn*

ADDRESS

*1422 Light St.*

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Y 2-1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33503

E 33503

145-003  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital 4-75* WARD)2-FULL NAME *Helen Smith*(a) RESIDENCE NO. *320 Diamond*  
(Usual place of abode)Length of residence in city or town where death occurred *2* yrs. *4* mos.ST. *W* WARDds. How long in U. S., if of foreign birth? *10* yrs. *10* mos. *10* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *1911*7 AGE Years *17* Months *—* Days *—* If LESS than 1 day, hrs. *—* or min. *—*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md*  
(State or country)10 NAME OF FATHER *W. W. Smith*11 BIRTHPLACE OF FATHER (city or town) *Va*  
(State or country)12 MAIDEN NAME OF MOTHER *Calverton*13 BIRTHPLACE OF MOTHER (city or town) *Va*  
(State or country)14 Informant *L. W. Smith*  
(Address) *320 Diamond St*15 Filed *3-19-28* *C. HAMPSON JONES, M. D.*  
Registar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 30 1928*17 I HEREBY CERTIFY, That I attended deceased from *Apr 30 1920* to *Apr 30 1928*, that I last saw her alive on *Apr 30 1928*, and that death occurred, on the date stated above, at *4 P* m.

The CAUSE OF DEATH\* was as follows:

*Abscess left lung followed by gangrenous condition of entire lung*  
(duration) *—* yrs. *—* mos. *10* ds.CONTRIBUTORY (Secondary) *Pneumonia following childbirth on Apr 1st 28*  
(duration) *—* yrs. *—* mos. *15* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *YES*What test confirmed diagnosis? *Clinical & Autopsy*  
(Signed) *Lewis Olds Taggart, M. D.*  
, 19 (Address) *University Hosp.*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33504

## CERTIFICATE OF DEATH.

32 E 33504

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 S. Stricker ST. 19-28 WARD)2-FULL NAME Myrtle E. Wimpling(a) RESIDENCE NO. 326 S. Stricker ST. 19-28 WARD

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 2, 19257 AGE Years 3 Months 4 Days 0 If LESS than 1 day, hrs. 0 or min. 0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Wm. E. Wimpling11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)12 MAIDEN NAME OF MOTHER Marie Hamilton13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)14 Informant William E. Wimpling (Address) 326 S. Stricker15 Filed 1928 C. HAMMON JONES, M. D. Registrar

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 192817 I HEREBY CERTIFY, That I attended deceased from April 3rd, 1928 to May 1st, 1928, that I last saw her alive on May 1st, 1928, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH\* was as follows:

Tubercular Meningitis(duration) yrs. mos. 21 ds.CONTRIBUTORY Cardiac Asthenia (Secondary)(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? NoWhat test confirmed diagnosis? Autopsy (Signed) Edgar Revellah, M. D. (Address) 24 N. Fulton Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL New Cathedral

DATE OF BURIAL

May 3 1928

20 UNDERTAKER

ADDRESS

Thompson & Sons 1200 N. Lombard

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33505

PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1927 Park Ave. St. 14 Ward)

2-FULL NAME

Isabel Keely Henry

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1927 Park AveSt. 14 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female white Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofEdward B. Keely

6 DATE OF BIRTH (month, day, and year)

Nov 7, 1882

7 AGE

Years

Months

Days

IF LESS than  
1 day... hrs.  
or... min..45 5 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore  
Md

10 NAME OF FATHER

Douglas C. Keely

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Lucia J. Amos

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant  
(Address)Edward B. Keely  
1927 Park Ave

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28May 2

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1928, to May 2, 1928.that I last saw him alive on May 2, 1928.and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY

Acute Pneumonia

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? m Date of m

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

M. D.

John E. Hays  
700 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Wood Ridge May 14 1928

20 UNDERTAKER

ADDRESS

John O. Mitchell 700 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 3 - 1928

JAMES J. JONES, M. D.  
Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33506

## CERTIFICATE OF DEATH.

E 33506

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of E. Cross St. St. 24-33 Ward 182)

## 2-FULL NAME

James J. Whalen.

## (a) RESIDENCE NO.

1100 Riverside Ave.

St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 11 mos. 26 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male.

## 4 Color or Race

White.

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single.

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

May 5, 1918

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

9

11

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Thomas E. Whalen.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

## 12 MAIDEN NAME OF MOTHER

Margaret Tyler.

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

## 14

Informant

Margaret Whalen. (mother)

(Address)

1100 Riverside Ave.

## 15

Filed

19

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, au-topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Drowning.Accidental fall from a wharf.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) John P. Reinhardt M. D. (Coroner)5/2, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Cross A.C.C.5-5-28

## 20 UNDERTAKER

ADDRESS

E+B Harle 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33507  
1-PLACE OF DEATHCity of BALTIMORE: (No. 128 W. Randall St.St. 23-32 Ward)2-FULL NAME Andrew J. Pulaski.(a) RESIDENCE NO. 128 W. Randall St.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.E 33507  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 Color or Race White. 5 Single, Married, Widowed, or Divorced, (write the word) Married.5a If married, was ~~XXXXXXXXXX~~  
HUSBAND of ~~XXXXXXXXXX~~ Anna Pulaski.6 DATE OF BIRTH (month, day, and year) July 17, 18827 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
45 9 14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town)..... Rochester N.Y.  
(State or country)10 NAME OF FATHER Joseph Pulaski.11 BIRTHPLACE OF FATHER (city or town)..... Poland.  
(State or country)12 MAIDEN NAME OF MOTHER Sasie.13 BIRTHPLACE OF MOTHER (city or town)..... Poland.  
(State or country)14 Informant Anna Pulaski. (wife)  
(Address) 1610 Light St.15 Filed..... 19..... Registrar G. HAMPTON

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said autopsy  
(Inquest, au-  
topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute dilatation of the Heart  
Edema and congestion of the lungs  
Chronic Gastritis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)(duration) .....yrs. ....mos. ....ds.  
(Signed) John J. Penland M. D.  
(Coroner)5/2, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St Marys Hampton 5-4-1928

20 UNDERTAKER ADDRESS

E + B Harle 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

ation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33508

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 115 Wickham Road,

CITY OF BALTIMORE: (No. 115 Wickham Road 28-71 WARD)

2-FULL NAME Kathleen Keller Hawthorne

(a) RESIDENCE No. 115 Wickham Road,  
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos.

ST. WARD

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 33508

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of or WIFE of Wm. F. Hawthorne

6 DATE OF BIRTH (month, day, and year) April 15, 1897

7 AGE Years 31 Months 17 Days 17 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Marion Va

10 NAME OF FATHER Joseph F. Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bristol Va

12 MAIDEN NAME OF MOTHER Sallie Legend

13 BIRTHPLACE OF MOTHER, (city or town) (State or country) Bristol Va

14 Informant Wm. F. Hawthorne (Address) 115 Wickham Road

15 HAMILTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1928.

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1928, to May 2, 1928, that I last saw her alive on May 1, 1928, and that death occurred, on the date stated above, at 1:45 a. m.

The CAUSE OF DEATH\* was as follows:  
Lobar Pneumonia.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Abscess of Lung.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. W. Shilling, M. D. 5/2, 1928 (Address) 1120 St Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Marion Va Undertaker Jos Jacobsen Son

May 9, 1928 ADDRESS 2178 Ben

MAY 3 - 1928

E 33509.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33509

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balt. City Hosp 4-6* ST., *26* WARD)2. FULL NAME *George Ruley*(a) RESIDENCE No. *1107 Bennett St.*

(Usual place of abode)

Length of residence in city or town where death occurred *24* yrs. mos. ds.WARD *1*

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of *Ann Ruley*6 DATE OF BIRTH (month, day, and year) *18 6 2*

7 AGE

Years *66*

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Victorian*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balt*  
(State or country)10 NAME OF FATHER *John Ruley*11 BIRTHPLACE OF FATHER (city or town) *B*  
(State or country)12 MAIDEN NAME OF MOTHER *Bertha P*13 BIRTHPLACE OF MOTHER (city or town) *Ind*  
(State or country)

14

Informant *Ann Ruley wife*  
(Address) *1107 Bennett St*

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/30 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*4-8 1928*, to *4/30 1928*.that I last saw him alive on *4/30 1928*.and that death occurred, on the date stated above, at *2.15 AM*.

The CAUSE OF DEATH\* was as follows:

*Chagrenia of stomach  
to Generalized Abdominal  
metastases*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? *Ind*Did an operation precede death? *Yes* Date of *4/10/28*Was there an autopsy? *No*What test confirmed diagnosis? *Alm. Frank*(Signed) *R. M. M. M. D.**4/3, 1928* (Address) *Balt City Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Oak Lawn Cemetery*

20 UNDERTAKER

*Lilly & Zuercher*

DATE OF BURIAL

*May 2 1928*

ADDRESS

*400 S. Wolfe St*

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



E 33510

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 161-001 E 33510

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square*)

WARD)

2. FULL NAME *Baby Girl Walsh*(a) RESIDENCE NO. *3306 Muller*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ST. *15* WARD *1*

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Infant*

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 1, 1928*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Maryland*10 NAME OF FATHER *Thomas R. Walsh*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Rose Wittmayer*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Maryland*

14

Informant (Address) *Rose Walsh, 3306 Muller St.*

15

Filed

MAY 3 - 1928

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 1 1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 1 1928* to *May 1 1928*that I last saw her alive on *May 1 1928* and that death occurred, on the date stated above, at *5:45* m.

The CAUSE OF DEATH\* was as follows:

*Congenital Stenosis with Prematurity*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Maternal Placenta Praevia*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *James E. Martin*, M. D.19 (Address) *Mutual Arts Bldg*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Int. Carmel Cems.*

20 UNDERTAKER

*Lilly & Zeiler Inc.*

DATE OF BURIAL

*May 3 1928*

ADDRESS

*403 S. Wolfe St.*

ation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33511

CERTIFICATE OF DEATH

E 33511

1-PLACE OF DEATH

City of BALTIMORE: (No. 4327 Greenmount A St. 27-48 Ward)

2-FULL NAME Emma Kramer

(a) RESIDENCE NO. 4327 Greenmount A St. 27-48 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1912, 1862

7 AGE Year 65 Months 11 Days 12 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.  
(State or country)

10 NAME OF FATHER Geo. Kramer

11 BIRTHPLACE OF FATHER (City or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Maria Huffer

13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)

14 Informant Edas Kramer  
(Address) 4327 Greenmount A

15 Filed May 3 - 1928 H. J. HANCOCK, M. D. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1918

17 I HEREBY CERTIFY, That I attended deceased from April 26th 1918 to May 1st 1918  
What I last saw him alive on April 30th 1918

and that death occurred, on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (duration) 5 yrs. 5 mos. 5 da.  
Arteriosclerosis  
(Secondary)

(duration) ? yrs. ? mos. ? da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Salivary Exon

(Signed) Geo. W. Harrison, M.D.

(Address) 401 E 28th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

London Park 3/19/18

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E. Balt.

E 33512

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33512

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 42 N. Lexington St. WARD 11)2-FULL NAME Therese E. Hittel(a) RESIDENCE NO. 22 42 N. Lexington St. WARD 11

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank H. Hittel6 DATE OF BIRTH (month, day, and year) Dec. 26-18627 AGE Years 65 Months 4 Days 5 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)10 NAME OF FATHER John Miller11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Kaufman13 BIRTHPLACE OF MOTHER (city or town) France (State or country)

## PARENTS

14 Informant Frank H. Hittel (Address) 22 42 N. Lexington St.

## 15

Filed 1928 C. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 192817 I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to May 1, 1928, that I last saw her alive on May 1, 1928, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic degenerative  
Endocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) Harold C. Kates, M. D.19 (Address) 2101 Thackeray Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery May 5 1928

20 UNDERTAKER

ADDRESS

George L. Schwab 2101 Thackeray Ave.

N.B.—WRITE PLAINLY, WITH CONFIDENCE. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33513

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 510 R

CITY OF BALTIMORE: (No 510 Rossiter Ave.,

ST. 27-48 WARD)

2-FULL NAME Lydia McGee

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No 510 Rossiter Ave.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 29 1848

7 AGE Years Months Days If LESS than 1 day, hrs or min.

79

5

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Scotland

10 NAME OF FATHER Robert McGee

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Scotland

12 MAIDEN NAME OF MOTHER Ellen Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant Mrs. Mary Aull (Address) 510 Rossiter Ave.

15

Filed

MAY 3 - 1928

C. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1928

17

I HEREBY CERTIFY, That I attended deceased from 5/1/23, 19, to 5/1/28, 19,

that I last saw her alive on 5/1/28, 19,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary)

(duration) 10 yrs. mos. ds.

(duration) 1 hour ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ew Date of

Was there an autopsy? ew

What test confirmed diagnosis?

(Signed) ew address M. D.

5/2/28 (Address)

321 E 25

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmount Cemetery May 3, 1928 19

20 UNDERTAKER

ADDRESS

Henry W. Means &amp; Son 505 N. Calvert

ation should be carefully supplied AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33515

## CERTIFICATE OF DEATH.

38 E 33515

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 4-25 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jenny Dancy(a) RESIDENCE NO. 9 W. Dancesville ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) ?5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) ?7 AGE Years 65 Months Days If LESS than 1 day, .... hrs. or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset10 NAME OF FATHER John B. Dancy11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Anna Dancy13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset14 Informant (Address) Reverend15 Filed 19 C. HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/192817 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1928, to Apr. 30, 1928 that I last saw him live on Apr. 30, 1928 and that death occurred, on the date stated above, at 2:00 A. M.

The CAUSE OF DEATH\* was as follows:

meningococcal septicemia

(duration) ? yrs. mos. ds.

CONTRIBUTORY Pneumonia (Secondary)(duration) yrs. mos. 6 ds.18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sub.(Signed) C. J. Sullivan, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 3 - 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33516

## CERTIFICATE OF DEATH.

E 33516

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mary Hospital 17-24* St., *17-24* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *592 W. Preston St.*

(Usual place of abode)

Length of residence in city or town where death occurred *Life*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Cosie Butler*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed....., 19

HARRISON JONES, JR.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3, 1928*

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an..... (Inquest or Inquiry.)

thereon and from the evidence obtained by said.....

find that said deceased came to..... death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Medicinal mass**Ant-burn*

CONTRIBUTORY (Secondary)

(Signed).....

(Coroner)

my 3 19 28 Address) *1639 Bunn*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death!.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*St. Ambrose Cem*

20 UNDERTAKER

*Samuel H. Hensley*ADDRESS *May 3, 1928**M. B. Hensley*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 33517

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33517

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 11-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William David Hamilton(a) RESIDENCE NO. 415 W. Monument ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of or) WIFE of Belle Hamilton6 DATE OF BIRTH (month, day, and year) 18567 AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Chas. D. Hamilton11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Caroline ?13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant (Address) Records

45 MAY 3 1928 HAMILTON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/192817 I HEREBY CERTIFY, That I attended deceased from Apr. 23, 1928, to Apr. 30, 1928 that I last saw him alive on Apr. 30, 1928 and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic parenchymatous nephritis  
arteriosclerosis hypertension(duration) yrs. 4 mos. ds.CONTRIBUTORY myocarditis, chronic

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? General & Sub.(Signed) C. Holmes Bond M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

DATE OF BURIAL

At. Auburn AveMay 3<sup>rd</sup> 1928

20 UNDERTAKER

ADDRESS 1128Samuel H. Hensley Dr. Biddle

Exact statement of OCCUPATION is very important. See instructions on back of certificates.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33519

## CERTIFICATE OF DEATH.

E 33519  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3744 Morley St. 10-70 Ward)2-FULL NAME Nicholas Miller(a) RESIDENCE NO. 3744 Morley St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. — mos. — ds.How long in U. S., if of foreign birth? 86 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 Color or Race

White5 Single, Married, Widowed,  
or Divorced, (write the word)Widowed

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Marguerite Miller

6 DATE OF BIRTH (month, day, and year)

April 24, 1833

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.95—8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workRetired Shoemaker(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Germany

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant

(Address)

Robert Miller3744 Morley St.

15 Filed

16

HAMPTON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2 1928

17

HEREBY CERTIFY, That I attended deceased from

May 23 1928 to May 2 1928and that I last saw him alive on May 2 1928and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH was as follows

Julish Obstruction  
+ Exhaustion(duration) ..... yrs. 3 mos. .... ds.

## CONTRIBUTORY

(Secondary)

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(signed)

5/3, 1928 (Address) 1509 W. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Loudon Park Cem.April 5, 1928

20 UNDERTAKER

ADDRESS 3109Charles W. Dill Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 33520

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33520

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Dallas

ST. 3-4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST.

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced, HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1928, to May 1, 1928.  
 that I last saw him alive on May 1, 1928,  
 and that death occurred, on the date stated above, at 10 p. m.  
 The CAUSE OF DEATH\* was as follows:  
Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1928 (Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33521

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Altamont Hotel* ST. *11-24* WARD)2-FULL NAME *Clarence Christie*(a) RESIDENCE NO. *Altamont Hotel* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs. mos. ds. How long in U. S., if of foreign birth? *45* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced, (write the word) *Widower*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Late Mary Shields Christie*6 DATE OF BIRTH (month, day, and year) *May 1845*7 AGE Years *87* Months *11* Days *2* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired-traveling auditor for B. & O. R. R.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Canada Nova Scotia*

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *"*12 MAIDEN NAME OF MOTHER *"*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *"*

14

Informant (Address) *Mr. James A. Rennie 3503 Prohatan Ave*

15

Filed

Registar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 2 1928*17 I HEREBY CERTIFY, That I attended deceased from *March 2nd 1928* to *May 2nd 1928*, that I have seen her alive on *May 2nd 1928*, and that death occurred on the date stated above, at *6:30 a. m.*

The CAUSE OF DEATH was as follows:

*Septic Pneumonia*CONTRIBUTORY (Secondary) *Shock resulting from a fall* (duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? (Signed) *Wm. J. Clark* M. D.*5/3, 1928* (Address) *12" Euter Plou*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

*for Joesend Don*ADDRESS *2173 Pm*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 3 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33522

E 33522

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 N. Caroline ST., 5-9 WARD)

## 2—FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

32 N. Caroline ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2, 1928

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER James Thomas

11 BIRTHPLACE OF FATHER (city or town) Crapo  
(State or country) Rochester, Co. Ind.

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) Crapo  
(State or country) Ind.14 Informant Mary Jackson  
(Address) 32 N. Caroline ST.15 Filed C. HAMPTON JONES, M. D.  
Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1928

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1928, to May 2, 1928,

that I last saw him alive on May 2, 1928,

and that death occurred, on the date stated above, at 10:25 m.

The CAUSE OF DEATH\* was as follows:

Signature: [Signature]

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Berry, M. D.

, 19 (Address) 1420 E. Chase

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

JNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health

DATE OF BURIAL

19

ADDRESS

MAY 3 - 1928

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 33523

HEALTH DEPARTMENT—CITY OF BALTIMORE

33523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital* St. *16-37* Ward)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Doe*

(Residence in Baltimore: No. *106* St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Male*

4-COLOR OR RACE,

*White*

5-Single, Married, Widowed, or Divorced, (Write the word.) *NK*

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

*about 55*

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*NK*

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed *1928*

*C. HAMMON JONES, M. D.*  
Registrar.

THE MORGUE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Apr. 29* 192*8*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* find that said deceased came to death *from* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was *Inanition* follows:

CONTRIBUTORY (Secondary)

*Malnutrition* (Duration) yrs. *10* mos. *10* ds.

*Malnutrition* (Duration) yrs. *10* mos. *10* ds.

*Malnutrition* (Duration) yrs. *10* mos. *10* ds.

*Malnutrition* (Duration) yrs. *10* mos. *10* ds.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

PER. FILE. S. W. BALL

MAY 3 - 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33524

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 500 Numsen St. 17-24 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 500 Numsen St. 17-24 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

Col.

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widower.

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

52

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

Porter

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md. Apr 27-1873

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

Bill Riddle  
512 Greenmount St.

## 15

Informant (Address)

James M. Jones  
10 N. 10th St.

Registrar

THE MORGUE

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....  
(Inquest, autopsy or inquiry)thereon and from the evidence obtained by said.....  
(Inquest, au-

topsy or inquiry.) And that said deceased came to..... death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Indigestion  
one hour  
(duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Error of diet  
(duration).....yrs.....mos.....ds.

(Signed)

(Coroner)

M. D.

(Address)

Edwards

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

UNIVERSITY OF MARYLAND

20 UNDERTAKER

ADDRESS

19

1928

S. M. Jones

MAY 3

Dep. W. H. S. Jones

NOTE.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33525

## CERTIFICATE OF DEATH

38

E 33525

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 115 S Dallas St. 3-4 Ward)

## 2-FULL NAME

Pearl Thomas

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 115 S Dallas St. 3-4 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 Color or Race

C

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 11 1893

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

84320

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

10 NAME OF FATHER

W. R.

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

W. R.

12 MAIDEN NAME OF MOTHER

W. R.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

W. R.

14

Informant

(Address)

Wm. Walker  
115 S Dallas St.

15

Date

May 3 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 28May 1

17

I HEREBY CERTIFY, That I attended deceased from

April 27, 1928, to May 1, 1928.that I last saw her alive on May 1, 1928.and that death occurred, on the date stated above, at 340 m.

The CAUSE OF DEATH\* was as follows:

Chronic Dementia  
Chronic Dementia  
(duration) yrs. 8 mos. da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

noDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

5-3-1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Cemetery  
Wendell J. ShippeyMay 3 1928  
308 S. Ala

M. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33526

E 33526

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Forster Ave.* *28-65* Ward)2-FULL NAME *Charles Fred Marsh*(a) RESIDENCE NO. *Forster Ave.* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Married*

5a If married, widowed, or divorced

HUSBAND of *Emma J. Marsh*  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*June 23 1860*

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min..

*67 11 9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Manufacturer of Cigars*9 BIRTHPLACE (city or town) *Yonkers*  
(State or country) *Ohio*10 NAME OF FATHER *Andrus M.*11 BIRTHPLACE OF FATHER (City or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Esther Holt.*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant *Emma Marsh*  
(Address) *Forster Ave.*15 Filed *C. HAMPTON JONES* Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 2 1928*17 I HEREBY CERTIFY, That I attended deceased from *Dec 1 1927* to *May 2 1928*that I last saw him alive on *May 2 1928*and that death occurred, on the date stated above, at *10:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Succ. Males (disease)*CONTRIBUTORY *Chronic Intestinal* (duration) yrs. *5* mos. *5* ds.

(Secondary)

18 Where was disease contracted *2 5* yrs. *5* mos. *5* ds.

If not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *Physician's report*(Signed) *John E. Hughes* M. D.(Address) *704 N. W. Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Smith-Rolfe Cemetery* *May 5 1928*

20 UNDERTAKER

ADDRESS

*Wilbur W. Shivers* *4214 Walnut**Form 6942-8**av.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33527

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1233 Patapiscu ST. 23-33

## 2-FULL NAME

(a) RESIDENCE. No. 1233 Patapiscu ST.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Heisser

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

George Heisser 1535 Mountpelier

15

Filed

C<sup>9</sup>

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr. 26 1928, to May 2 1928,

that I last saw her alive on May 2 1928,

and that death occurred, on the date stated above, at 6:05 P. M.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis

CONTRIBUTORY (duration) 10 yrs. Cardiac Mitralis (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry Heiser M. D.

(Address) 933 Heiser

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Olivet Cemetery

May 5 1928

20 UNDERTAKER

ADDRESS

George Schilling &amp; Sons

1126 Monument

tion should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Y 3 - 1928

E 33528

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33528

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 16-37 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max A. Albert(a) RESIDENCE NO. 4919 Eastern Ave. ST. 16-37 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of or WIFE of ?6 DATE OF BIRTH (month, day, and year) Oct 6 18677 AGE 61 Years 5 Months 27 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Fredrick A. Albert11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Adela E.13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 BALTIMORE CITY HOSPITALInformant (Address) Records15 C. HAMPSON JONES, M. D.Filed AY 3-1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3/1928

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 12, 1928 to May 3, 1928that I last saw him live on May 3, 1928and that death occurred, on the date stated above, at 3:20 A. M.

The CAUSE OF DEATH\* was as follows:

Diabetes mellitus(duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis General & Sub.(Signed) C. Williams Boyd M. D., 19 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Unity Cem.May 4 1928

20 UNDERTAKER

Waldell Dippel Long - Edent

Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.





E 33530

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33530

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 404 Pearl ST. 17-25 WARD)2. FULL NAME Simon Dickerson(a) RESIDENCE NO. 404 Pearl

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. life mos.ST. 17-25 WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofJulia Dickerson

6 DATE OF BIRTH (month, day, and year)

7/18/59

7 AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.64 — —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

beef butcher

(c) Name of employer

unknown9 BIRTHPLACE (city or town)  
(State or country)Balto

10 NAME OF FATHER

unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country)unknown

12 MAIDEN NAME OF MOTHER

unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)unknown

## PARENTS

14 Informant  
(Address)Julia Dickerson  
404 Pearl St.

## 15

Filed

C. HAMPSON JONES, M. D.  
AKK

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2 1928

17

HEREBY CERTIFY, That I attended deceased from  
April 13, 1928, to May 2, 1928,  
that I last saw him alive on May 2, 1928and that death occurred, on the date stated above, at 9:10 P m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) 0 yrs. 0 mos. 5 ds.CONTRIBUTORY  
(Secondary)none(duration) 0 yrs. 0 mos. 0 ds.18 Where was disease contracted  
if not at place of death?at homeDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

Clinical symptoms(Signed) R. B. Thompson, M. D.5/3, 1928 (Address) 607 W. Franklin

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

St. Peter's Cemetery5/7/1928

UNDERTAKER

ADDRESS

Geo. H. Holland 1631 Duval St.

B.—WRITE PLAINLY, WITH CARE. INFORMATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33531

## CERTIFICATE OF DEATH.

E 33531

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 439 Druid Hill St. 11-25 Ward)

## 2-FULL NAME

Willie Jackson(a) RESIDENCE NO. 439 Druid Hill St. 11-25 WardLength of residence in city or town where death occurred 45 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race Col5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single6 DATE OF BIRTH (month, day, and year) 1883

7 AGE

Years 45

Months

Days

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.  
(State or country)10 NAME OF FATHER Foster Jackson11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)12 MAIDEN NAME OF MOTHER Harriet Stewart13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)

14

Informant Julia Dixon  
(Address) 404 Pearl St

15

Filed C. HAMMOND JONES, M.D.  
APR Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) May 3 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.)and that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Phlebotomy(duration) 6 yrs. mos. ds.CONTRIBUTOR Acute Endocarditis  
(Secondary)(duration) 7 yrs. mos. ds.(Signed) J. H. Lusk(Address) Coroner

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.  
Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. AuburnDate of Burial 5/7/192820 UNDERTAKER Mrs. Geo. H. HollandADDRESS 1631 Druid Hill Ave

PHYSICIANS should state cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

E 33532

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33532

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *3716 Yosemite* ST. *1-3* WARD)2—FULL NAME *Elizabeth A. King*(a) RESIDENCE NO. *38 Bollington* ST.

(Usual place of abode)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *65* yrs. *0* mos. *0* ds.How long in U. S., if foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced, ~~HUSBAND~~ (or) WIFE of *John King*6 DATE OF BIRTH (month, day, and year) *May 1856*

7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or .... min.

*72**11**0*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *city*10 NAME OF FATHER *Patience Wilkinson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Me.*12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Me.*

14

Informant *E. King*(Address) *38 S. Bollington*

15

FILED

19

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/2/28*

17

I HEREBY CERTIFY, That I attended deceased from

*April 28, 1928, to May 2, 1928*that I last saw him alive on *May 2, 1928*and that death occurred, on the date stated above, at *11 a* m.

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia.*(duration) .... yrs. .... mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Wm. J. Quinn*, M. D.*7/8, 1928* (Address) *350 Garrison*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Trinity Cathedral May 5, 1928*  
*John A. Moran 3000 E. Baltimore*

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION OF DEATH is important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33533

## CERTIFICATE OF DEATH.

\* 45 E 33533

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Stagnes Hosp 75-72*)

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Abraham Rosenberg*(a) RESIDENCE NO. *1910 N. Papa St. Phila Pa.*

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male.**White**Married*

5a If married, widowed or divorced, HUSBAND of (or) WIFE of

*Lillian Rosenberg*

6 DATE OF BIRTH (month, day, and year)

*Oct 20 1891*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

*26**6**—*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Salesman*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Russia.*

10 NAME OF FATHER

*Samuel Rosenberg*

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia.*

12 MAIDEN NAME OF MOTHER

*Lova Schwartz*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Russia.*

14

Informant (Address)

*Lillian Rosenberg 1910 N. Papa St. Phila Pa.*

15

Filed

*1928**C. HAMMOND JONES, N. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 3 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*May 3 1928 to May 3 1928*

that I last saw him alive on

*May 3 1928*

and that death occurred, on the date stated above, at

*1020 p.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Coecum*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*General Carcinomatosis*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

*yes* Date of *9 Mo. ago*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Microscopic & Clinical**Augustine P. Vonschuh, M.D.**Stagnes Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Phila Pa**5/10 1928*

20 UNDERTAKER

ADDRESS

*John Lewis 1439 E. 11th St*Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33534

## CERTIFICATE OF DEATH.

90 E 33534

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2421 St. Paul St.)Ward) 12-50

Registered No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) Residence No. 2421 St Paul  
(Usual place of abode)

St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 94 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Single  
Married,  
Widowed,  
or Divorced.  
(Write the word.)Female White5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of6-DATE OF BIRTH (month, day and year) Nov 9-1833

7-AGE,

If LESS than 1 day,

94 yrs. 5 mos. 24 ds.

...hrs. or...min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work. ....(b) General nature of industry,  
business, or establishment in  
which employed (or employer)....

(c) Name of employer.....

9-BIRTHPLACE (city or town).... Balto Md  
(State or Country).10-NAME OF FATHER Henry Coulter11-BIRTHPLACE OF FATHER (city or town).... Balto Md  
(State or Country).12-MAIDEN NAME OF MOTHER, Not Known13-BIRTHPLACE OF MOTHER (city or town).... Balto Md  
(State or Country).14- (Informant) Mrs Geo Hamm(Address) 2421 St Paul St

15-

Filed

19:

HAMILTON JOHNS, M.D.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5/3/2817- I HEREBY CERTIFY, That I attended deceased from  
January 24 19 28 to May 3 19 28  
that I last saw him alive on May 3 19 28  
and that death occurred, on the date stated above, at 9:15 a.m.  
The CAUSE OF DEATH\* was as follows:MyocarditisCONTRIBUTORY  
(Secondary)(Duration) many yrs. mos. ds.Cardiac decomposition(Duration) 1 yrs. mos. ds.18-Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) George M. Smith M. D.19 (Address) 2421 St Paul St\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL

DATE OF BURIAL,

Local (PK City)5/5/28

20-ENTERTAINER

ADDRESS

Geo Reimbold & Co11 Eymouth

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 33535

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33535

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals ST. 7 WARD)2-FULL NAME William Vanhorn(a) RESIDENCE NO. 867 E. 28th st.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos.ST. 7 WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of or WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18807 AGE Years 48 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Record (Address)15 MAY 4 - 1928 HAMPTON JONES, M. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 192817 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1928 to May 3, 1928that I last saw him alive on May 3, 1928and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) Unknown yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical & lab.(Signed) L. E. M. Jones, M. D.5-3-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Woodlawn Cem. May 5, 1928

UNDERTAKER

ADDRESS

Geo. Seimbach Sons 525 N. Lyndhurst

maison should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33536

E 33536

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 621 W Biddle St. 17-24 Ward)2-FULL NAME Marie B. Thompson(a) RESIDENCE NO. 621 W Biddle St. 17-24 Ward(Usual place of abode)  
Length of residence in city or town where death occurredyrs. 10 mos. 13(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. da.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Col 5 Single, Married, Widowed, or Divorced, (write the word) Child5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child6 DATE OF BIRTH (month, day, and year) June 19-19277 AGE Years 10 Months 13 Days 13 IF LESS than 1 day.....hrs. or.....min.8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Philip Thompson11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Melba Munge13 BIRTHPLACE OF MOTHER (city or town) Wichita (State or country)14 Informant (Address) Melba Thompson  
621 W Biddle15 Filed 1928 G. HAMPTON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Mt Auburn Cem 5-4-1928

20 UNDERTAKER ADDRESS

Daniel Easton Be ur

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33537

## CERTIFICATE OF DEATH.

E 33537

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital 3-4* St., *3-4* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *715 S. Spring St. 11* Ward *11*

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. *0* mos.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *Col* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Emma Burel*6 DATE OF BIRTH (month, day, and year) *1906*7 AGE Years *22* Months *—* Days *—* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *D.C.*10 NAME OF FATHER *Lee Mary*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *D.C.*12 MOTHER NAME OF MOTHER *McLure*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *D.C.*

14

Informant (Address) *Taylor Wilson 715 S. Spring St.*

15 Filed

16

HARRISON JONES, N. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 1 1928*17 I HEREBY CERTIFY, That I took charge of the remains of *Autopsy* held *See page* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Autopsy* and that said deceased came to *his* death on the day stated above.The CAUSE OF DEATH is as follows: *See that record**Homicide* *Mar 3/28*CONTRIBUTORY (Secondary) *Septic Pneumonia**May 3* *900 S. 4th* *May 1**20* (Address) *14310 Boney*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

*McAuliffe Bur* *5-4 1928*

20 UNDERTAKER

ADDRESS *916**Daniel E. Ford* *Da an*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33538

E 33538

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 Oak St ST. 12-51 WARD)2-FULL NAME Mollie Washington(a) RESIDENCE No. 2208 Oak St ST. 12-51 WARD(Usual place of abode)  
Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of -6 DATE OF BIRTH (month, day, and year) -7 AGE Years 18 Months 9 Days 10 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic(b) General nature of industry, business, or establishment in which employed (or employer) no(c) Name of employer no9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Richard S. Washington11 BIRTHPLACE OF FATHER (city or town) (State or country) DC12 MAIDEN NAME OF MOTHER Mollie Washington13 BIRTHPLACE OF MOTHER (city or town) (State or country) DC14 Informant Richard Washington (Address) 2208 Oak St15 Filed 19 HAMMON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 192817 I HEREBY CERTIFY, That I attended deceased from May 1 1928, to May 3 1928, that I last saw him alive on May 3 1928, and that death occurred, on the date stated above, at 8 a m

The CAUSE OF DEATH\* was as follows:

Acute pneumonia  
phthisisCONTRIBUTORY (Secondary) Quercus (duration) yrs. mos. ds. 1018 Where was disease contracted if not at place of death? UnknownDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Physical Exam (Signed) H. Hall, M. D., 19 (Address) 426 E 23rd St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER Wm. E. Carter DATE OF BURIAL 5/4/28ADDRESS 916

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

E 33539

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 N. Mount ST. 19-27 WARD)2-FULL NAME Benjamin Payne(a) RESIDENCE NO. 32 N. Mount Sp

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.  mos.  ds.ST. WARD (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs.  mos.  ds. 

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE C5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of or WIFE of Julia Payne6 DATE OF BIRTH (month, day, and year) 1880

7 AGE

Years 48Months Days 1880If LESS than 1 day, hrs.  or min. 

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) 040(c) Name of employer Gas & Electric Co9 BIRTHPLACE (city or town) Camel City  
(State or country) La10 NAME OF FATHER Benj. Payne11 BIRTHPLACE OF FATHER (city or town) Virginia  
(State or country)12 MAIDEN NAME OF MOTHER Winnia13 BIRTHPLACE OF MOTHER (city or town) Virginia  
(State or country)

14

Informant George Payne  
(Address) 32 N. Mount

15

Filed 1928

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1 19 28

17

I HEREBY CERTIFY, That I attended deceased from April 26th, 19 28, to April 30th, 19 28, that I last saw him alive on Apr 30th, 19 28, and that death occurred, on the date stated above, at Ben.

The CAUSE OF DEATH\* was as follows:

Lobar PneumoniaCONTRIBUTORY (duration) yrs.  mos.  ds.   
(Secondary) Carotid Arteries18 Where was disease contracted unknown  
if not at place of death? noDid an operation precede death? no Date of Was there an autopsy? noWhat test confirmed diagnosis? or(Signed) Charles H. H. H. H., 19 (Address) 119 1/2 Carrollton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT St. Mary'sDATE OF BURIAL May 4, 192820 UNDERTAKER James H. BiddleADDRESS 32 N. Mount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

MAY 4 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33540

PLACE OF DEATH

38 E 33540

REGISTERED NO.

City of BALTIMORE: (No. 1319 Stockton 15-23 Ward)

2-FULL NAME

Ernest Sylvester Duckett

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1319 Stockton St.

Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 2 mos. ds.How long in U. S. if of foreign birth 17 yrs. 2 mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 1911

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

17 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

10 NAME OF FATHER

Samuel Edw. Duckett

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Charles County Md.

12 MAIDEN NAME OF MOTHER

Mary Howkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Charles County Md.

14

Informant

(Address)

Father1319 Stockton St.

15

Filed

4-1926HANCOCK JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

May 2-28

I HEREBY CERTIFY, That I attended deceased from

March 1st 1928 to May 2nd 1928that I last saw him alive on March 30th 1928and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

1319 Stockton St

Did an operation precede death?

no

Date of

Was there an autopsy?

noWhat test confirmed diagnosis? History and physical

(Signed)

Ernest S. Minton, M. D.

, 19

(Address)

2001 Penna. av.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Peter7/5/1928

20 UNDERTAKER

ADDRESS

Mrs. Geo. H. Kollig 1631 Duval St.

tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 7-17-26 - A Co. - 200 Bks.

1. B. - WRITE PLAINLY, WITH UNFADING INK. Exact statement of OCCUPATION is  
tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE  
OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.  
very important.

HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 33541

1-PLACE OF DEATH

City of BALTIMORE: (No.

3333 N. Charles St.

Ward 12-49

2-FULL NAME

Anna Parrish Williams.

(a) RESIDENCE NO.

3333 N. Charles

St.

Ward 9-7.

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 2 ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 Color or Race

White

5 Single, Married, Widowed, or  
Divorced, (write the word).

Married

5a If married, widowed, or divorced

~~HUSBAND~~  
(or) WIFE of

George Cooke Williams

6 DATE OF BIRTH (month, day, and year)

Sept. 19, 1865

7 AGE

Years

Months 62

Days 5

IF LESS than  
1 day hrs.  
or min.. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Housewife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town)

Seneca Falls, N.Y.

(State or country)

10 NAME OF FATHER

William Parrish

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Seneca Falls, N.Y.

12 MAIDEN NAME OF MOTHER

Lucy Brewster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Seneca Falls N.Y.

14

Informant  
(Address)

Rodney W Williams  
Riderwood, Md.

15 Filed

19

C. HAMPTON JONES, M.  
Registrar

REGISTERED NO.

E 33541

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2 1928

17

I HEREBY CERTIFY. That I attended deceased from

7-27, 1928, to 5-2, 1928,

that I last saw him alive on 5-2, 1928,

and that death occurred, on the date stated above, at 9.50 P. M.

The CAUSE OF DEATH\* was as follows:

CHRONIC NEPHRITIS

CONTRIBUTORY

(Secondary)

(duration) 3+ yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John L. Somers, M. D.

19 (Address) 1129 St. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) Whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

London Park Cem. Balto.

Date of Burial

May 4, 1928

20 UNDERTAKER

Henry W Jenkins & Sons Co

ADDRESS

McCulloh &  
Orchard Sts  
Balto.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33542

## CERTIFICATE OF DEATH

REGISTERED NO.

33542

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Geneva Apts* St. *27th* Ward)2-FULL NAME *Rosa Woolfolk Ober*(a) RESIDENCE NO. *Geneva Apts* St. *Greenway* Ward *27th*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F*4 Color or Race *white*5 Single, Married, Widowed, or Divorced, (write the word) *widow*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Genl. Robt Ober*6 DATE OF BIRTH (month, day, and year) *July 22 1855*

7 AGE

Years *72*Months *9*Days *11*

IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Columbus Ga*

(State or country)

10 NAME OF FATHER *Wm. Gordon Woolfolk*

11 BIRTHPLACE OF FATHER (City or town)

(State or country) *Muscogee Co. Ga.*12 MAIDEN NAME OF MOTHER *Maria Byrd Nelson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Clarke Co Va*

14

Informant *Gustavus Ober Jr*  
(Address) *Lutherville Md.*15 Filed *MAY 4 - 1928*Registrar *W. H. NORTON*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 1924*, to *May 3 1928*that I last saw him alive on *May 3 1928*and that death occurred, on the date stated above, at *12:10 P.M.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia - lobar*(duration) *0* yrs. *0* mos. *7* ds.CONTRIBUTORY *Arterio-sclerosis*(Secondary) *Auricular fibrillation*(duration) *5+* yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no*

Date of

Was there an autopsy? *no*What test confirmed diagnosis *Physical signs*(Signed) *Gordon Nelson*

M. D.

(Address) *715 Park av.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Green Mount*Date of Burial *May 5 1928*20 UNDERTAKER *Henry H. Jenkins & Sons*ADDRESS *McCulloch*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33543

## CERTIFICATE OF DEATH.

198 E 33543  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 4-25 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 625 Sarah Ann St. \_\_\_\_\_ Ward \_\_\_\_\_(Usual place of abode)  
Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Negro 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) unknown7 AGE Years 44 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

## 15

Filed

G. HANCOCK JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said \_\_\_\_\_

and that said deceased came to \_\_\_\_\_ death

on the day stated above.

The CAUSE OF DEATH was as follows:

Homicide  
Amputation due to incised wounds of face & right forearm  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(Signed) Eugene J. M. D. (Coroner)4/30, 1928 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Wm. J. Jones May 3 1928  
Boardman 218 pierce St

tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33544

## CERTIFICATE OF DEATH.

100-001

E 33544

1-PLACE OF DEATH *St. Agnes Hospital*CITY OF BALTIMORE: (No. *20-64*)2-FULL NAME *Raymond Gilbert, Jr.*(a) RESIDENCE NO. *2529 Ashton*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD (If non-resident give city or town and State)

How long in U. S., If of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 14, 1927*7 AGE *one* Years *11* Months *18* Days *1* If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto*10 NAME OF FATHER *Raymond Gilbert*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ill.*12 MAIDEN NAME OF MOTHER *Edith Jones*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ind.*14 Informant (Address) *Raymond Gilbert 2529 Ashton St.*15 Filed *1928* HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 2 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 29, 1928* to *May 2, 1928*, that I last saw him live on *May 2, 1928* and that death occurred, on the date stated above, at *8:55 a.m.*

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia uncomplicated*(duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Culture*(Signed) *Edith H. H. M.D.* 1928 (Address) *2000 Hollins St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Loredan Park*

DATE OF BURIAL

20 UNDERTAKER

*Harry H. H. 1531 W. Loredan St.*

Information should be carefully supplied. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

E 33545

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33545

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1336 Carroll*)2-FULL NAME *Peter Johnson*(a) RESIDENCE NO. *1336 Carroll*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**Colored**widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Emily Johnson*

6 DATE OF BIRTH (month, day, and year)

*Mar. 17, 1868*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*60**1**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

*040*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*  
*md*

10 NAME OF FATHER

*William Johnson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balt*  
*md*

12 MAIDEN NAME OF MOTHER

*Nellie Brown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balt*  
*md*

14

Informant (Address)

*Nellie Nash (daughter)*  
*1336 Carroll St*

15

Filed

MAY 4 - 1928

C. HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 2 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar. 3 1928* to *May 1 1928*that I last saw him alive on *May 1 1928* and that death occurred, on the date stated above, at *3 p. m.*

The CAUSE OF DEATH\* was as follows:

*Intermittent nephritis*(duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. *1* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Monley, Doug*

M. D.

Address *727 Washington St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS *322**Mrs. Kate R. Williams**R. Schroeder*

mation should be carefully supplied. Exact statement of OCCASION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33546

## CERTIFICATE OF DEATH

49 E 33546

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Colonial Hospital* St., *7-13* Ward)2-FULL NAME *Harry B. Weaver*(a) RESIDENCE NO. *1714 E. Eager St.* St. *7-13* Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Sallie A. Weaver* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *March 18-1866*7 AGE Years *62* Months *1* Days *14* IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Photographer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *William H. Weaver*11 BIRTHPLACE OF FATHER (City or town) *Baltimore, Md.* (State or country)12 MAIDEN NAME OF MOTHER *not known*13 BIRTHPLACE OF MOTHER (city or town) *not known* (State or country)14 Informant *Sallie A. Weaver* (Address) *1714 E. Eager St.*15 Filed *1928* HAMMOND JONES, M. D. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 2* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *April 26* 19 *28*, to *May 2* 19 *28*, that I last saw him alive on *May 2* 19 *28*, and that death occurred, on the date stated above, at *6 P.*

The CAUSE OF DEATH\* was as follows:

*Uterus - Carcinoma of Prostate*

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Cytoscopy*  
(Signed) *Chas. J. Hechtman, M. D.*  
, 19 (Address) *Colonial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Greenmount Cemetery*

20 UNDERTAKER

*Geo. W. Zirkler*

Date of Burial

*May 5 1928*

ADDRESS

*1737 E. Eager St.*

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33547

## CERTIFICATE OF DEATH.

46 E 33547

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *270* Ward *37*)2-FULL NAME *Mrs Barbara Kappel*(a) RESIDENCE NO. *3811 Fernwood Ave* St. *Ward*

(Usual place of abode)

Length of residence in city or town where death occurred *37* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of *Phillip Kappel*

6 DATE OF BIRTH (month, day, and year)

*Oct. 14-1891*7 AGE Years *36* Months *7* Days *19* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) *Baltimore, Md.*10 NAME OF FATHER *Wm. Oresser*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Prussia*12 MAIDEN NAME OF MOTHER *Katherine Canich*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Germany*14 Informant *Phillip Kappel*  
(Address) *3811 Fernwood Ave*15 Filed *1925* 19 *RECEIVED* Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3* 192*8*

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Embolism  
Pleural Effusion on right side*(duration) yrs. *2* mos. *1* ds.CONTRIBUTORY *Original Cpts. (Carcinomatous)*  
(Secondary) *(Bilateral)*(duration) yrs. *1* mos. *1* ds.(Signed) *George J. Ellis* M. D.

(Coroner)

*5/4, 1925* (Address) *2739 Eastern Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mt. Carmel Cemetery*

Date of Burial

*May 7 1928*

20 UNDERTAKER

*Geo. W. Zinkler*

ADDRESS

*1737 E. Eager**at*

tion should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33548

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

129 ✓  
REGISTERED 33548

City of BALTIMORE: (No. 437 W. Henrietta St. St. 21-31 Ward)

2-FULL NAME Samuel Jennings. (C)

(a) RESIDENCE NO. 437 W. Henrietta St. St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred 54 yrs. 11 mo. 19 ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, HUSBAND of  
XXXXXXXXXX  
XXXXXXXXXX

Mary Jennings. (C)

6 DATE OF BIRTH (month, day, and year) May 12, 1878 / 1889

7 AGE Years 38 54 Months 11 Days 19 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) Do not know.  
(State or country)

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) Do not know.  
(State or country)14 Informant Mary Jennings. (C) wife.  
(Address) 437 W. Henrietta St.15 Filed 1928 19 HAMPSON JONES, M. B.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy &amp; inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy and inquiry and that said deceased came to his death on the day stated above.

18 CAUSE OF DEATH was as follows:  
Chronic Myocarditis, edema and congestion of the lungs. Chronic Nephritis. Uraemia.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed) M. D. (Coroner)

5/4 - 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. ....mos. ....ds. In the State .....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER M. B. Jones  
ADDRESSExact statement of OCCUPATION is  
Very Important. See instructions on back of certificate.  
User should be carefully supplied.

E 33549

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33549

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *101 N Fulton Ave* ST. *9-27* WARD)2-FULL NAME *Wm J Hulshoff*(a) RESIDENCE NO. *101 N Fulton Ave* ST. *9-27* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *59* yrs. *5* mos. *26* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Catherine A Hulshoff*6 DATE OF BIRTH (month, day, and year) *Nov 6, 1868*

7 AGE

Years *59*Months *5*Days *26*If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Druggist*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)10 NAME OF FATHER *John B. Hulshoff*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Eliz. Werman*13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)

14

Informant *Mrs. C. A. Hulshoff*  
(Address) *101 N Fulton Ave*

15

Filed

MAY 4 - 1928

C. HANCOCK

M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 2, 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 1, 1927* to *May 2, 1928*, that I last saw him alive on *May 2, 1928*, and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH\* was as follows:

*Acute Myocarditis*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *M. D. O'Neill*

M. D.

14. 1928

(Address) *108 N Fulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral Cemetery**May 5, 1928*

20 UNDERTAKER

ADDRESS

*Fred. A. Trause & Son**703 Hanover St*

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



E 33550 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 E 33550

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital* ST. *2572* WARD)2-FULL NAME *Mr Philip Morheiser*(a) RESIDENCE No. *3804 Church Ave*

(Usual place of abode)

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Verna Morheiser*6 DATE OF BIRTH (month, day, and year) *Dec. 15, 1870*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*57**54**18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Shoemaker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Dixon and Bertlett*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore**md*

10 NAME OF FATHER

*John S. Morheiser*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto**Maryland*

12 MAIDEN NAME OF MOTHER

*Elenora W. Reynold*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto.**md*

14

Informant

(Address)

*Mr Verna Morheiser*  
*3804 Church Ave*

15

Filed

19

*C. H. JONES*  
*Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *4-12*, 19 *28*, to *5-3*, 19 *28*.that I last saw him alive on *5-3*, 19 *28*and that death occurred, on the date stated above, at *10.55 a m*

The CAUSE OF DEATH\* was as follows:

*Hypernephroma (rt)*

(duration)

yrs. *8*

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. *3*

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of *yes* *4/18/28*

Was there an autopsy?

*yes*

What test confirmed diagnosis?

*May & Nichols*

(Signed)

*F. D. D'Adda*

M. D.

(Address)

*St Agnes Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Louisa Park Cemetery**May 7* 19 *28*

UNDERTAKER

ADDRESS

*W. B. Cook**1003 W. East*

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33551

## CERTIFICATE OF DEATH.

90 E 33551

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. 20-27 Ward)

## 2-FULL NAME

Miss Lucy Burns

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

Home for the Aged of the U. S. Church Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

Life time

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 2 yrs. 2 mos. 2 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofMaiden

## 6 DATE OF BIRTH (month, day, and year)

Oct 20 - 1858

## 7 AGE

Years

69

Months

6

Days

13IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

## 10 NAME OF FATHER

John Burns.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.

## 12 MAIDEN NAME OF MOTHER

Lucy Duwall

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

## 14

Informant

Etta Cuddy

(Address)

400 N. Fulton Ave.

## 15

Filed

1928H. R. Jones, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 2, 1928, to May 3, 1928,that I last saw her alive on May 2, 1928,and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis(duration) 3 yrs. 3 mos. 3 ds.

## CONTRIBUTORY

(Secondary)

Myocarditis(duration) 1 yrs. 1 mos. 1 ds.

## 18 Where was disease contracted

If not at place of death! ✓Did an operation precede death! no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Clinical methods(Signed) Geo. C. Shannon, M. D.May 3, 1928 (Address) 700 Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount OlivetMay 4 1928

## 20 UNDERTAKER

George J. SmithADDRESS 532HollinsExact statement of occupation is  
OF DEATH in plain terms, so that it may be properly classified.  
VERY IMPORTANT. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33552

E 33552

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 7-10 Ward)

## 2-FULL NAME

Julian E. Packer

## (a) RESIDENCE NO.

2512 McElderry StSt. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 Color or Race

white

## 5 Single, Married, Widowed, or Divorced. (write the word)

Widower

## 5a If married, widowed, or divorced

HUSBAND of

Hattie M Packer

## 6 DATE OF BIRTH (month, day, and year)

Don't know

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.75

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Glass worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

La.

## 10 NAME OF FATHER

Don't know

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Don't know

## 12 MAIDEN NAME OF MOTHER

Don't know

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Don't know

## 14

Informant

Mrs. Louis Peppler (Daughter)

(Address)

3419 Liberty Hts. Ave

## 15

Filed

1920HAMMON JONES

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 1/28

## 17

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, autopsy or inquiry.)and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Intracranial Hemk Struck by Automobile at McElderry St & Milton Avenue.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner)

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of burial

Landon Park Cemetery May 4 1928

## 20 UNDERTAKER

ADDRESS

Robt J Turner 1 Broadway

tion should be carefully supplied. Exact statement of occupation of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

MAY 4 - 1920





E 33554

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33554

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Servina W. Webb(a) RESIDENCE No. 1447 N. Parmer ST., 90 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 45

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn10 NAME OF FATHER John R. West11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn12 MAIDEN NAME OF MOTHER Elise Dickerson13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn14 BALTIMORE CITY HOSPITAL Informant (Address) Reverend15 MAY 4 - 1928 Filed 1928 HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29/ 19 28

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1928 to April 29, 1928 that I last saw her live on Apr. 29, 1928 and that death occurred, on the date stated above, at 8:10 P.m.

The CAUSE OF DEATH\* was as follows:

Initial myocardial stenosis.  
Myocarditis chronic & acute  
Etiology - rheumatic  
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sub(Signed) C. Stulman Borge, M. D.  
19 (Address) BALTIMORE CITY HOSPITAL

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Thomas E. Kelson1303

TION is very important. See instructions on back of certificates.

## E 33555 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAY 4 - 1928

HAMILTON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from April 30, 1928, to May 4, 1928, that I last saw him alive on May 4, 1928, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:

Osteomyelitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 1

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. Lawrence Fabry M. D.

, 19 (Address) St. Joseph Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Westernport Md May 4, 1928  
Chas. P. Waiss & Son 118 W. Royal Ave

E 33556

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33556

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day 13 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

1928

HAMILTON COMPS, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

May 2, 1928, to May 3, 1928,

that I last saw her alive on 11 15 A M, 1928,

and that death occurred, on the date stated above, at 11 15 A m.

The CAUSE OF DEATH\* was as follows:

Premature (7 mo)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman A. Vora, M. D.

, 19 (Address) St Joseph Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33557

## CERTIFICATE OF DEATH

90

E 33557

## 1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1727 Hope St 9-18

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME Antonia Riefner

(a) RESIDENCE NO. 1727 Hope Street

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 21, 1928, to May 3, 1928,

that I last saw her alive on May 2, 1928,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed)

M. D.

5/31, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



E 33558

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *15-61* WARD)2-FULL NAME *Robert G. Pollard*(a) RESIDENCE NO. *2310 Allendale Road* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct. 12, 1926*7 AGE Years *1* Months *6* Days *29* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.* (State or country)10 NAME OF FATHER *Chas. R. Pollard*11 BIRTHPLACE OF FATHER (city or town) *Balto* (State or country)12 MAIDEN NAME OF MOTHER *Mary Moltz*13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country)14 Informant *Chas. R. Pollard* (Address) *2310 Allendale Rd*15 *C. HAMPSON JONES, M.D.* *1928*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3 1928*17 I HEREBY CERTIFY, That I attended deceased from *May 2*, 1928, to *May 3*, 1928,that I last saw him alive on *May 3*, 1928,and that death occurred, on the date stated above, at *945* a. m.

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *Home* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Myron G. Jull*, M. D.5/3, 1928 (Address) *Sydenham Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Loudon Park May 5 1928*  
*John O. Mitchell*

CAUSE OF DEATH is very important. See instructions on back of certificates.

E 33559

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44 E 33559

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 339 East 22<sup>nd</sup> ST., 17-50 WARD)2-FULL NAME Thomas R Jenkins(a) RESIDENCE NO. 339 East 22<sup>nd</sup>

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

March 21/1881

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min47113

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Automobile

(b) General nature of industry, business, or establishment in which employed (or employer)

Mechanic

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Magothy A.A. Co Md

## 10 NAME OF FATHER

George F Jenkins11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Magothy A.A. Co Md

## 12 MAIDEN NAME OF MOTHER

Elizabeth A Bright13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Baltimore Md

## 14

Informant  
(Address)Mr George F Jenkins  
339 East 22<sup>nd</sup> st

## 15

Filed

1928 C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1928

17

I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1927, to May 4, 1928.that I last saw him alive on May 3 1928  
and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of  
Stomach with General Metastasis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Hypostolic Pneumonia  
(duration) yrs. 4 mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) R. L. Taylor M. D.19 (Address) Westworth apt

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

## DATE OF BURIAL

Magothy Cemetery A.A. Co Md, May 6 1928

## 20 UNDERTAKER

## ADDRESS

John F Denny 715 Liset st

TION is very important. See instructions on back of certificate.

## E 33560 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33560

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 Greenmount Ave ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R. Parrish

(a) RESIDENCE NO. 1037 Greenmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sarah I Richards

6 DATE OF BIRTH (month, day, and year) Oct., 31, 1851

7 AGE Years Months Days 1 If LESS than 1 day, hrs or min. 76 6 2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Brick layer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Wm. Parrish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Sarah I. Parrish (Address) 1037 Greenmount Ave

15 Filed 1928 C. HAMPSHIRE JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1928

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1928, to May 2, 1928, that I last saw him alive on May 2, 1928,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH was as follows:

Nephritis

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1037 Greenmount Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) James M. Fenelon, M. D.

6/3, 1928 (Address) 707 E. Chase St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Baltimore

May 5, 1928

20 UNDERTAKER

ADDRESS

Rita Wiedefeld 914 Greenmount Ave

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33561

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 226 N. High St., 5 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

16 Filed

19

Per

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-  
topsy or inquiry.) And that said deceased came to

on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

19

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

2112

MORQUE

UNIVERSITY OF MARYLAND

Baltimore Health

MAY 2 - 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33562

## CERTIFICATE OF DEATH.

90 E 33562

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 Low St., 5-8 Ward)2-FULL NAME Mary M. M. M.(a) RESIDENCE NO. 100 Low St. 5-8 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

C. HAMPSON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 - 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest  
(Inquest, au-  
topsy or inquiry.)and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)(Signed) W. J. Jones M. D.  
(Coroner)  
1928 Address 1639 Bay\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place  
of death.....yrs.....mos.....ds. In the  
State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death!

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL Date of Burial

20 UNDERTAKER

Greenleaf Health.

ADDRESS

19

1928

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

45-1220

THE MORGUE

UNIVERSITY OF MARYLAND

MAY 1

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33563

## CERTIFICATE OF DEATH.

182 E 33563

1-PLACE OF DEATH Found floating in the water at  
City of BALTIMORE: (No. Foot of Woodall St. 2435 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(a) RESIDENCE NO. Do not know.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced. (write the word)

Male.

White

Do not know.

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Do not know.

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

45

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.

Do not know.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Do not know.

10 NAME OF FATHER

Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Do not know.

12 MAIDEN NAME OF MOTHER

Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Do not know.

14

Informant  
(Address)

Police Report. S.D.

15

Filed

G. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Body found April 30, 1928

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry and that said deceased came to his death  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Drowning.

Probably accidental.

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

M. D.

5/4, 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place In the  
of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death: \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVAL

PUBLIC CEMETERY. MAY 4 - 1928

20 UNDERTAKER

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.  
very important.

E 33564

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33564

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2616 Oswego Ave. St. 15-38 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Crawford

(a) RESIDENCE NO. 2616 Oswego Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 12th. 1858

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

70

00

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md.

10 NAME OF FATHER Samuel Crawford

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER Francis Dougherty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14 Informant Charles J. Crawford

(Address)

2616 Oswego Ave.

15 Filed

C. HAMPTON JONES, M. D.

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

April 2, 1928, to May 2, 1928

that I last saw him alive on May 1, 1928

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic obstructive

Pneumonia

(duration) 12 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Plummer, M. D.

19

(Address) 1734 N. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Johns Westminster Md 5/5/28

20 UNDERTAKER

ADDRESS

Harry N. Witzke 1531 N. Lombard St.

Exact Statement of Occupation of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

4-1828

33565

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St Agnes Hospital*CITY OF BALTIMORE: (No. *19-28*)2-FULL NAME *Mrs Clara V Collins*(a) RESIDENCE No. *1515 Ramsay*  
(Usual place of abode)Length of residence in city or town where death occurred *5* yrs. *5* mos.ST. *19-28* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. *19-28* WARD *57*  
(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *John W. Collins*6 DATE OF BIRTH (month, day, and year) *Jan 1st 1878*7 AGE Years *50* Months *5* Days *1* If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *housework*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Benj & Stinner*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto.*12 MAIDEN NAME OF MOTHER *Ann Hutchins*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*14 Informant *John W. Collins*  
(Address) *1515 Ramsay St.*15 *C. HAMPSON JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-2* 19 *28*17 I HEREBY CERTIFY, That I attended deceased from *Aug 27*, 19 *27*, to *5-2*, 19 *28*, that I last saw *her* alive on *5-2*, 19 *28* and that death occurred, on the date stated above, at *8 P* m.

The CAUSE OF DEATH\* was as follows:

*Diabetes Mellitus*

CONTRIBUTORY (Secondary)

*about 1*  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *usual tests*(Signed) *H. E. Knipp*, M. D.19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *London Park Cemetery* DATE OF BURIAL *May 5 1928*  
20 UNDERTAKER *Harvey H. Witzke* ADDRESS *1531 N. Lombard St.*

TION is very important See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33566

## CERTIFICATE OF DEATH.

E 33566

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5408 Cleveland Ave. 16-36

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 5408 Cleveland Ave.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Bettyman Marville

6 DATE OF BIRTH (month, day, and year)

June 23, 1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

63

10

11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Tulbott Co. Md.

10 NAME OF FATHER

Mr. Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Margaret Haddaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant

(Address)

Thurman B. Marville 5408 Cleveland Ave

15

Filed

1828

19

HAMPSON JONES M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 4 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 5

1928

to May 4

1928

that I last saw him alive on

May 3

1928

and that death occurred, on the date stated above, at 5.35 a.m.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis, Ch. Myocarditis, Ch. Ent. nephritis, Atrophic Arteriosclerosis

(duration)

1+ yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Ant. cardiac dilatation

(duration)

yrs.

mos.

5 ds.

18 Where was disease contracted if not at place of death?

Same

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical findings

(Signed)

S. L. Bishop

M. D.

May 4, 1928 (Address)

501 Shundan Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

May 7, 1928

20 UNDERTAKER

ADDRESS

Mr. Mrs. John W. Tufel 501 N. Fayette

33567

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

1928

19

C. HAMPSON JONES, M.

Per

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1928, to May 4, 1928, that I last saw her alive on May 4, 1928, and that death occurred, on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Harman G. Voss, M. D.

(Address) St. Joseph's Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33568

## CERTIFICATE OF DEATH.

REGISTERED NO.

185 E 33568

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 10-69 Ward)2-FULL NAME George J. Dorner(a) RESIDENCE NO. 2148 Vine

(Usual place of abode)

St. 10-69 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 Color or Race

W

5 Single, Married, Widowed, or Divorced. (write the word)  
Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofAugusta S. Pippig

6 DATE OF BIRTH (month, day, and year)

Jan 17/1881

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.47315

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....Labirer(b) General nature of industry, business, or establishment in which employed (or employer).....Balto Hide &(c) Name of employer.....Tallow Association

9 BIRTHPLACE (city or town).....

(State or country)

Balto., Md.

10 NAME OF FATHER

John Dorner

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Lena Steg

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Germany

14

Informant  
(Address)Wife15 Filed 1928Per R.H.H.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry and that said deceased came to this death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Odema of brain- Delerium TremensGeneral Arteriosclerosis(Autopsy at St. Joseph Hospital)CONTRIBUTORY Accidental fracture of

(Secondary)

left ankle (Potts)(Signed) J. P. Jones M. D.

(Coroner)

5/4/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

St. Joseph Hospital, 150 N. Balto. St.

OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

33569

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital*)

WARD

2-FULL NAME *Baby George Metcalf*(a) RESIDENCE NO. *1803 Lemon St.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *5* mos. *11* ds.ST. *20th* WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 27 27*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*5**10**11*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto. Md.*

10 NAME OF FATHER

*George Metcalf*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore. Md.*

12 MAIDEN NAME OF MOTHER

*Edith*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore. Md.*

14

Informant

(Address)

*Geo. Metcalf*  
*1803 Lemon St.*

15

Filed

1928

G. HAMMOND JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3 1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 2 1928* to *May 3 1928* that I last saw him alive on *May 3 1928*and that death occurred, on the date stated above, at *110. m*

The CAUSE OF DEATH\* was as follows:

*Intussusception of Glis-canal valve.*(duration) yrs. mos. *8* ds.

CONTRIBUTORY (Secondary)

*obstruction* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *5/3/28*Was there an autopsy? *No*

What test confirmed diagnosis?

Signed *Augustine P. Vondra* M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-STATE OF BURIAL

*Baltimore Cemetery* *May 28 1928*

20 UNDERTAKER

*St Agnes Hospital, 1803 N. Baltimore St.*



E 33570

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33570

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2127 N. Lexington* ST. *W. 45* WARD)2-FULL NAME *Arthur P. Seab*(a) RESIDENCE NO. *2127 N. Lexington* ST. *W. 45* WARD  
(Usual place of abode)Length of residence in city or town where death occurred *47* yrs. *4* mos. *26* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Willie E. Seab*6 DATE OF BIRTH (month, day, and year) *Dec 18 1880*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *47* *4* *26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Law-Manager*(b) General nature of industry, business, or establishment in which employed *Summit Co*(c) Name of employer *New York*9 BIRTHPLACE (city or town) (State or country) *Baltimore, Md*10 NAME OF FATHER *Henry C. Seab*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore, Md*12 MAIDEN NAME OF MOTHER *Elizabeth Egan*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore, Md*

14

Informant (Address) *Arthur P. Seab*

15

Filed

C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 1928* to *May 3 1928*, that I last saw him alive on *May 2 1928*, and that death occurred, on the date stated above, at *1 P. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of abdomen*

CONTRIBUTORY (Secondary)

(duration)

yrs. *10*

mos.

ds.

(duration)

yrs. *4*

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Walter E. Eubank**5/4 1928*(Address) *2002 N. Lexington*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

PLACE OF BURIAL

UNDERTAKER

ADDRESS

E 33571

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 159-002 ✓  
E 33571

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 522 S Duncan St. 2-4 Ward)

2-FULL NAME Teresa Biernat

(a) RESIDENCE NO. 522 S Duncan St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female

White

Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 3-1927

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

9

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town)

(State or country)

Balto Md

10 NAME OF FATHER

Stanislaus Biernat

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Rozalia Slowik

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

PARENTS

14 Informant Stanislaus Biernat

(Address) 522 S Duncan St

15

G. HAMPSON JONES, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 4 1928

17

I HEREBY CERTIFY That I attended deceased from

May 1, 1928, to May 4, 1928,

that I last saw him alive on May 4, 1928,

and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH\* was as follows:

Congestive heart failure

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of.....

Was there an autopsy?

What test confirmed diagnosis?

Signed: J. R. Jones, M.D.

(Address) 401 S Chester

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Rosary May 5 1928

20 UNDERTAKER

ADDRESS

John M. Weber 401 S Chester

OF DEATH in plain terms, so that it may be understood by all. See instructions on back of certificates.

E 33572

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33572

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1921 N. Reister St.* ST. *8-13* WARD)2-FULL NAME *Catherine A. Grubb*(Residence in Baltimore: No. *1233 N. Gay St.* St.; *76* yrs., *0* mos., *0* da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

*Married, Widow*  
(Write the word.)

## 6-DATE OF BIRTH,

*October 16, 1852*  
(Month) (Day) (Year)

## 7-AGE,

*76* yrs., *6* mos., *17* da.If LESS than 1 day,  
...hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*9-BIRTHPLACE,  
(State or Country),*Balt City*

## 10-NAME OF FATHER,

*B. Z. German*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Balt City*

## 12-MAIDEN NAME OF MOTHER

*Georgiana Clark*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Balt Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Charles W. Beeby*(Address) *1921 N. Reister St.*

## 15-

Filed

*1928**C. HAMMONS JONES, M. D.*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*May 3, 1928*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*March 5, 1928, to May 3, 1928,*that I saw her alive on *May 3, 1928,*and that death occurred, on the date stated above, at *9:30 A. m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis*(Duration) *4-5* yrs., *0* mos., *0* da.CONTRIBUTORY  
(Secondary)(Duration) *0* yrs., *0* mos., *0* da.(Signed) *Henry Annin Pushkin, M. D.**May 3, 1928* (Address) *1804 E. Euter St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs., *0* mos., *0* da. In the State *0* yrs., *0* mos., *0* da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Green Mount Cemetery**May 5, 1928*

## 20-UNDERTAKER

ADDRESS *1203 N. Broadway*

E 33573

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33573

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 E. Biddle ST. 8-13 WARD)

## 2-FULL NAME

Mary E. Bradfield

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1902 E. Biddle ST.,

## WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs.  mos.  ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William E. Bradfield

## 6 DATE OF BIRTH (month, day, and year)

Sept 23 1856

## 7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs  
or .... min.71710

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

House Work

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

West Virginia

## 10 NAME OF FATHER

David B. Gadeby

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

West Virginia

## 12 MAIDEN NAME OF MOTHER

Mary Butts

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

West Virginia

## 14

Informant  
(Address)Leonard Bradfield  
1902 E. Biddle St

## 15

Filed

19

C. HAMMON JONES, M. D.RRM

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1928, to May 3, 1928, that I last saw her alive on May 2, 1928, and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage from arteriosclerosis

(duration)

yrs.

mos.

ds. 9

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? none

(Signed)

S. Lee Magnusson, M. D.5/4, 1928 (Address)1206 E. Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Baltimore CemeteryMay 5, 1928

## 20 UNDERTAKER

ADDRESS 1203C. Perry Lutz7 Broadway

CAUSE OF DEATH SECTION IS VERY IMPORTANT. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33574

## CERTIFICATE OF DEATH.

E 33574

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

6117. Bentalon St 16-69

WARD)

## 2-FULL NAME

Mary C. Long.

(a) RESIDENCE NO.

6117. Bentalon St.

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

mos.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Wm. Long.

6 DATE OF BIRTH (month, day, and year)

March-23-1856

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

72

1

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Md.

10 NAME OF FATHER

John H. Amend.

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Bridget Brown.

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ireland.

14

Informant  
(Address)Mrs. John Colley.  
6117 Bentalon St.

15

Filed

19

HAMPSON JONES, M. D.

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Apr 28, 1928, to May 2, 1928.

that I last saw him live on May 2, 1928.

and that death occurred, on the date stated above, at 9:40 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia

(duration) 4 yrs. 2 mos 2 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) J. Edgar Talbot M. D.

1928 (Address) 1355 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

New Cathedral Cemetery May 5 1928

20 UNDERTAKER

ADDRESS

Charles J. Schwab 5057 Maine St

CAUSE OF DEATH in plain terms, so that it may be properly classified.  
TION is very important. See instructions on back of certificates.

E 33575

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33575

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *9-17* WARD)2-FULL NAME *Agnes Lynch*(a) RESIDENCE NO. *Baldwin, Md.* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. *01*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *1901*7 AGE *26* Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Keeping*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Co. Md.*10 NAME OF FATHER *John Lynch*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Co. Md.*12 MAIDEN NAME OF MOTHER *Lynch*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Co. Md.*

14

Informant (Address) *John Lynch*

15

Filed *1928*

19

C. HAMPTON JONES, M. D.

Registrar *R.R.B.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/7/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*4/23/28*, 19, to *5/7/28*, 19,that last saw her alive on *5/4/28*, 19,and that death occurred, on the date stated above, at *SP* m.

The CAUSE OF DEATH\* was as follows:

*Encephalitis*(duration) yrs. mos. *19* ds.CONTRIBUTORY *cardiac dilatation* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *T. P. Thompson*, M. D., 19 (Address) *St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Long Green Cath Cem* *Apr 2, 1928*  
*Hornberger & Gross* *Bensenville, Md.*

3671  
33576

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 49 E 33576

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITALST. 7-9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

John P. Nolan

## (a) RESIDENCE

(Usual place of abode)

Collingwood & Elmore ST.

## WARD

1 Ray N. Y.

Length of residence in city or town where death occurred

yrs.

mos.

3

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

4-6-63

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Manufacturer

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

N. Y.

## 10 NAME OF FATHER

Michael Nolan

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Bridget O'Connell

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14

Informant (Address)

Records -

## 15

FILE

19

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 4 - 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1928, to May 4, 1928.that I last saw him alive on May 4, 1928.and that death occurred, on the date stated above, at 9:35 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral aneurysm Rupture(duration) 1 yrs. 0 mos. 0 ds.

## CONTRIBUTORY (Secondary)

Alcoholism (duration) 1 yrs. 0 mos. 7 ds.

## 18 Where was disease contracted

if not at place of death? N. Y.Did an operation precede death? No Date of 2-2Was there an autopsy? YesWhat test confirmed diagnosis? Cytological(Signed) Robert M. McKim, M. D.5/4, 1928 (Address) J. H. H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Albany N. Y.5/5/28

## 20 UNDERTAKER

## ADDRESS

Hughes & Jones Inc. 420 W. Bay

E 33577

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33577

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine HospitalST. 22-30 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. White(a) RESIDENCE No. 643 S. Paca St., Balto., Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of or) WIFE of Mrs. Reva White6 DATE OF BIRTH (month, day, and year) Jan. 10, 18957 AGE Years 43 Months 3 Days 23 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter(b) General nature of industry, business, or establishment in which employed (or employer) Seaman(c) Name of employer S.S. Alleghany9 BIRTHPLACE (city or town) Richmond (State or country) Virginia10 NAME OF FATHER Edward White11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)12 MAIDEN NAME OF MOTHER Nannie Cuzin13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)14 Informant Records, U.S. Marine Hospital (Address)15 5-1928 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 19 28

17

I HEREBY CERTIFY, That I attended deceased from April 19, 19 28 to May 3, 19 28,that I last saw him alive on May 3, 19 28,and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis, active, chronic(duration) undetermined yrs. mos. ds.CONTRIBUTORY Myocarditis (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted unknown if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? X-ray & laboratory(Signed) J. M. Leuball, M. D., 19 (Address) U.S. Marine Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Zion ct DATE OF BURIAL May 5 192820 UNDERTAKER V. K. Brown & Son 108 W. Monty St

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33578

## CERTIFICATE OF DEATH.

90 E 33578

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1526 Ashland Ave St. 7-13 Ward)

2-FULL NAME Catherine Green

(a) RESIDENCE NO. 1526 Ashland St

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

F

C

unknown

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

about 60

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....none(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country)

Va ?

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

14

Informant J. N. Waters

(Address) 141 W. Hill St

15

Filed 1928 C. HAMPSON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry and that said deceased came to her death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Chr. Myocarditis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

M. D.

5/3/28

(Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Mt. Calvary Cem.

May 5 1928

20 UNDERTAKER

ADDRESS 1027

John H. Toadorn

Hill

OF DEATH in plain terms, so that it may be understood by all.  
very important. See instructions on back of certificate.

## E 33579 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33579

1-PLACE OF DEATH

1003 Spence St

CITY OF BALTIMORE: (No. ...)

ST. ... WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Gertmole Dural

(a) RESIDENCE NO.

1003 Spence St

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

ST. ... WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FEMALE

WHITE

MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

ELMER DUVALL

6 DATE OF BIRTH (month, day, and year)

May 26-1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

11

3

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore co md

10 NAME OF FATHER

Valentine Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Elmer Duvall 1003 Spence St

15

Filed

1928 C. HAMPSON, JES. M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1928 to May 3, 1928 that I last saw her alive on May 3, 1928 and that death occurred, on the date stated above, at 10 30 P. M. The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

(duration) 4 yrs. mos. ds.

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Wm A. Strauss

M. D.

May 3, 1928 (Address)

1201 Griffiss Ave

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

M. D. Oliver &amp; Co

UNDERTAKER

ADDRESS

Edward J. J. J.

2257 W. 1st St.

E 33580

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *514 Mc Mechen* ST. *14-70* WARD)2-FULL NAME *Van Lear Turner Brown*(a) RESIDENCE, No. *514 Mc Mechen* ST., WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *9* mos. *14* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M*

4 COLOR OR RACE

*C*

5 Single, Married, Widowed, or Divorced (write the word)

*SINGLE*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *7-20-26*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**9**14*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*  
*Moses Brown*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Virginia*

12 MAIDEN NAME OF MOTHER

*Aida Turner*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore County*

14

Informant (Address)

*Aida Turner*  
*514 Mc Mechen St*

15

Filed

19

*C. HAMPSON JONES* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-4* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from *4-20*, 19*28*, to *5-4*, 19*28*, that I last saw him alive on *5-3*, 19*28*, and that death occurred, on the date stated above, at *3 P.* m. The CAUSE OF DEATH\* was as follows:*Acute Bronchitis*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *14* ds.(duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Physical Exam*

(Signed)

*William J. Harris* M. D.

19

(Address) *1200 Penn Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*McMechen Ave* *6/5* 19*28*  
*Dr. J. Carter* *Be ne*

TION is very important. See instructions on back of certificates.

E 33581

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

32 E 33581

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1875 Penn St. WARD 32)

## 2-FULL NAME Joseph Edmunds

(a) RESIDENCE NO. 1875 Penn St.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

General Public

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pa.

10 NAME OF FATHER

Harry Edmunds

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Bertha Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant (Address)

Aene V. Hombin 1119 E. 27th St.

Filed 5-1928, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/28

I HEREBY CERTIFY, That I attended deceased from 5/1/28, 1928, to 5/4/1928, that I last saw him alive on 5/3/1928,

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH\* was as follows:

Tubercular meningitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) R. E. Ellis, M. D.

1978 (Address) 724 W. 1st St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Blackstone Va

5/5/1928

20 UNDERTAKER

ADDRESS 916

Quintanilla

Be ne



E 33582

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33582

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1021 Madison ave.* ST. *11-74* WARD)

## 2. FULL NAME

*Dennie Banks*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *1021 Madison ave.* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *1* mos. *1* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female Col.**Married*

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year)

*1863*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*65*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*VA*

10 NAME OF FATHER

*Not known*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*VA*

12 MAIDEN NAME OF MOTHER

*Not known*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*VA*

14

Informant (Address)

*Leulla Coates 1021 Madison ave*

15

Filed

19

*C. H. HANSON*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3 1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 2 1928* to *May 3 1928* that I last saw her alive on *May 3 1928* and that death occurred, on the date stated above, at *8 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *2*(duration) yrs. mos. ds. *2*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*William T. M. D.*

/4, 1928 (Address)

*1928 Penna Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

CREMATION OR RE-

DATE OF BURIAL

Burial - Buckenham

*5/5 1928*

20 UNDERTAKER

ADDRESS *916**Henri E. E. E.**Be me.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33583

## CERTIFICATE OF DEATH.

66 E 33583

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 904 Pear Alley St. 17-24 Ward)2-FULL NAME Wm Smith(a) RESIDENCE NO. 904 Pear Alley St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race col 5 Single, Married, Widowed, or Divorced Single5a If married, widowed, or divorced, name of husband or wife Wm Smith6 DATE OF BIRTH (month, day, and year) 18887 AGE Years 40 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) unknown  
(State or country) \_\_\_\_\_10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_14 Informant Neighbors  
(Address) \_\_\_\_\_15 Filed 1926, 19 \_\_\_\_\_  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest  
(Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Alcoholism  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) F. B. Smith(Address) Coroner

(Coroner)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem Date of Burial 4/5 192820 UNDERTAKER Samuel H. H. H.ADDRESS 578

OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33584

## CERTIFICATE OF DEATH.

101-001  
E 33584

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

Provident Hosp. 17-24  
Ward

## 2-FULL NAME

Nellie L. Thomas

## (a) RESIDENCE NO.

770 George

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

Cauc

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

## 6 DATE OF BIRTH (month, day, and year)

Aug 2 - 1926

## 7 AGE

Years

Months

Days

1

8

1

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md

## 10 NAME OF FATHER

Edw Thomas

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md

## 12 MAIDEN NAME OF MOTHER

Nellie Young

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md

## 14

Informant

(Address)

Nellie Thomas  
770 George St.

## 15

Filed

19

HARVEY JONES

Registrar

## REGISTERED NO.

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

## 17

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. one.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

(Address) M. D.

(Coroner) Coroner.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mr. Cuban Ave 4 5 28

## 20 UNDERTAKER

ADDRESS

Samuel Hensley 1340

OF DEATH IN plain terms. See instructions on back of certificate.  
very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33585

## CERTIFICATE OF DEATH.

57 E 33585

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *26-37* WARD2-FULL NAME *Frances Peluso*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *3929 Mt. Pleasant Ave.* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Married*6 DATE OF BIRTH (month, day, and year) *Don't know.*

7 AGE

Years *38*

Months \_\_\_\_\_

Days \_\_\_\_\_

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Italy*10 NAME OF FATHER *Basco*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

PARENTS

14 Informant *Joseph Peluso*  
(Address) *3929 Mt. Pleasant Ave.*

15

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/4/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*4/15/28*, 19, to *5/4/28*, 19.that I last saw her alive on *5/4/28*, 19.and that death occurred, on the date stated above, at *2 A.* m.

The CAUSE OF DEATH\* was as follows:

*Diabetes mellitus*

(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. \_\_\_\_\_ mos. *20* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Herman G. Vorys*

M. D.

, 19 (Address) *St Joseph Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Stanislaus Cem* *May 7*, 19*28*

20 UNDERTAKER

ADDRESS

*John Ullrich* *2008 Orleans*

5-1928



E 33586

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33586

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 S. Hurham ST. 2-4 WARD)2-FULL NAME Elvis Kane(a) RESIDENCE NO. 224 S. Hurham ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

single.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 2 1914

7 AGE

13

7

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

N.Y.

10 NAME OF FATHER

Wm. Kane

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

12 MAIDEN NAME OF MOTHER

Lena Reed

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Va.

14

Informant  
(Address)Wm Kane (father)  
224 S. Hurham St.

15

Filed

19

HAMPSON

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 20 1928 to May 2 1928that I last saw him alive on May 1 1928and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

unknown

Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

Physical

(Signed)

R. J. Young

M. D.

May 3 1928 (Address)

1429 E. Monument St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Catholic cemetery

May 5 1928

20 UNDERTAKER

ADDRESS

Robert Williams 1515 N. E. 1st St

TION is very important. See instructions on back of certificate.

E 33587

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33587

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital* ST. *25-7* WARD)2. FULL NAME *Mr Eugene Jones*(a) RESIDENCE No. *Hilton Ave. Catonsville*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred *1* mos. *—* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widower*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*April 3 / 40*6 DATE OF BIRTH (month, day, and year) *5 / 3 / 1840*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*87**11**29*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Retired*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto.*

10 NAME OF FATHER

*Jones*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto*

14

Informant (Address)

*Mrs E. Schaaf  
Hilton Ave Catonsville*

15

Filed

5-1928

C. HAMPSON JONES, M. D.  
*AKW* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/2/1928*

17

I HEREBY CERTIFY, That I attended deceased from *3-19*, 19 *28*, to *5-2*, 19 *28*.that I last saw him alive on *5-2*, 19 *28*.and that death occurred, on the date stated above, at *12.40 P.* m.

The CAUSE OF DEATH\* was as follows:

*Arterio sclerosis with gangrene of right foot*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Broncho pneumonia*(duration) yrs. mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis?

*Clinical  
Augustine P. Von Schue D.  
St Agnes Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Carmel*

DATE OF BURIAL

*5/5 1928*

20 UNDERTAKER

*Philip Herwig*ADDRESS *2016 Orleans*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33588

## CERTIFICATE OF DEATH

129-E 33588

## 1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 2423 E Biddle ST., 8-12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Vernon Cool(a) RESIDENCE NO. 2423 E Biddle ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (Write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Mary D. Leavitt

6 DATE OF BIRTH (month, day, and year)

Dec 17-1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44416

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

John A Cool

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Idea V Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt

14

Informant

Mrs Mary D Cool

(Address)

2423 E Biddle

15

Filed

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3-1928

17

I HEREBY CERTIFY, That I attended deceased from

Oct 27, 1927, to 3-3, 1928that I last saw him alive on May 2, 1928and that death occurred, on the date stated above, at 1:50 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial NephritisCONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Leavitt, M. D.(Address) 513 N Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Co.

DATE OF BURIAL

May 5 1928

20 UNDERTAKER

Frank H. Brackley

ADDRESS

1906 Calver

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33589

## CERTIFICATE OF DEATH.

33589

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 14 Ward 20)2-FULL NAME Mr. L. O. O.(a) RESIDENCE NO. 1570 Butler St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

MaleColoredMarried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

34 Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

HAMPSON JONES, M. D.

Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 199817 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)hereon and from the evidence obtained by said Inquestand that said deceased came to this death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Dysentery

CONTRIBUTORY

SepticemiaMay 8 1998 (Address) 1430 Bway

\*State the Disease Causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death!.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 4/15/98

20 UNDERTAKER

ADDRESS

Samuel H. Hushy 18 Biddle

OF DEATH in plain terms. See instructions on back of certificate.



212204  
E 33590

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

\* 113 E 33590

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 7-9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Lester Cooper

## (a) RESIDENCE NO.

(Usual place of abode)

Candiff - Md -

ST. WARD

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

2-10-28

## 7 AGE

Years

2

Months

Days

24

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Md -

## 10 NAME OF FATHER

Evan Cooper

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md -

## 12 MAIDEN NAME OF MOTHER

Susie Miller

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md -

## 14

Informant (Address)

Records -

## 15

Filed 5-1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 7 1928

## 17

I HEREBY CERTIFY, That I attended deceased from March 18, 1928, to May 4, 1928, that I last saw him live on May 4, 1928, and that death occurred, on the date stated above, at 7:25 P.M.

The CAUSE OF DEATH\* was as follows:

Dysentery type unspecified

(duration) yrs. mos. 16 ds.

## CONTRIBUTORY (Secondary)

Otitis media + pharyngitis

(duration) yrs. mos. 16 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/24/28

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. B. Bennett

M. D.

(Address)

Johns Hopkins Hosp.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

## UNDERTAKER

## ADDRESS

Delta Va.

5-5 1928

E. H. B. H. 1158 West St.

E 33591

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33591

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. *529 Biddle St* St. *17-24* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Samuel Tucker*(a) RESIDENCE NO. *529 Biddle St* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male* *White* *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1874*

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.. *54 yrs*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Waiter*

9 BIRTHPLACE (city or town)

(State or country) *Md.*10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (City or town)

(State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Unknown*

14

Informant (Address) *Luther Tucker 1227 Duval Hill Ave*

15 Filed

19

HAMPSON JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 4 1928*

19

17

I HEREBY CERTIFY, That I attended deceased from

*March 1 1928* to *May 4 1928*that I last saw him alive on *May 3 1928*and that death occurred, on the date stated above, at *50* m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia Tuberculosis*CONTRIBUTORY *Acute Malnutrition* (duration) yrs. 2 mos. ds.

(Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chemical* (Signed) *Christie* M. D.(Address) *1504 McMillan*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*St. Luke's Reformation* *May 7 1928*

20 UNDERTAKER

ADDRESS

*Mrs. Geo. H. Holland 163 Duval Hill Ave*

OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

E 33592

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

124 E 33592

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Balti City Hospital 9-46 ST. 9-46 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Mary Rainey(a) RESIDENCE NO. 2634 Boone

(Usual place of abode)

ST. 9-46 WARDLength of residence in city or town where death occurred 15 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 15 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18867 AGE 42 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Wm Frost11 BIRTHPLACE OF FATHER (city or town) MD (State or country)12 MAIDEN NAME OF MOTHER Rose Franklin13 BIRTHPLACE OF MOTHER (city or town) MD (State or country)14 Informant Sadie Rainey (Address) 2634 Boone St15 Filed 5-19-28 19 C. HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2 19 2817 I HEREBY CERTIFY, That I attended deceased from 4-12, 19 28, to 5-2, 19 28that I last saw her alive on 5-2-28, 19 28and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH\* was as follows:

Empyema of Gall Bladder  
Chronic Myocarditis(duration) 1 yrs. 2 mos. 24 ds.CONTRIBUTORY (Secondary) Myocardial Infarction(duration) 1 yrs. 1 mos. 1 ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? yes Date of 5-1-28Was there an autopsy? noWhat test confirmed diagnosis? operation(Signed) Blaywell M. D., 19 (Address) Balti City Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mt. Auburn

DATE OF BURIAL

5/6 19 2820 UNDERTAKER Chas. A. Alexander

ADDRESS

1400 Dundas  
Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33593

## CERTIFICATE OF DEATH

47 E 33593  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 7 E. Cor St. Paul & 23<sup>rd</sup> St. Ward 17-53)2-FULL NAME Helen Newman Cook(a) RESIDENCE NO. 210 Longwood Rd. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 0 ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? 33 yrs. 2 mos. 13 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 Color or Race White5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Mr. Walter H. Cook  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) February-21-1875

7 AGE

Years 53Months 2Days 13IF LESS than  
1 day..... hrs.  
or..... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) Taunton(State or country) Mass10 NAME OF FATHER Stephen M. Newman11 BIRTHPLACE OF FATHER (City or town) Maure

(State or country)

12 MAIDEN NAME OF MOTHER Mary L. Colburn13 BIRTHPLACE OF MOTHER (city or town) Maine

(State or country)

14 Informant Mr. Walter H. Cook  
(Address) 210 Longwood Road.15 Filed 1928

19

G. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-1928

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1927, to 5-4-1928,  
that I last saw her alive on 5-4-1928,  
and that death occurred, on the date stated above, at 4:20 P. M.  
The CAUSE OF DEATH\* was as follows:  
Carcinoma of breast  
(removed 3 yrs. ago)CONTRIBUTORY Metastases in pleura(Secondary) and lung

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(duration) about 8 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

If not at place of death? \_\_\_\_\_

Did an operation precede death? Yes Date of 1924 or 5Was there an autopsy? noWhat test confirmed diagnosis? Physician Ex. Ray(Signed) E. Lepp

, 19

(Address) 7 E. Cor. St. Paul & 23<sup>rd</sup> St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul CemeteryDate of Burial May-7 192820 UNDERTAKER Stewart & Mowen CoADDRESS 108 W. North Ave.



## E 33594 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33594

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mr Hope Records 28-63* ST. *WARD*)2-FULL NAME *Margaret Loftus*(a) RESIDENCE No. *Mr Hope Records*

(Usual place of abode)

Length of residence in city or town where death occurred *46 yrs. 8 mos. 8 ds.*

ST.,

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? *46 yrs. 8 mos. 8 ds.*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Aug 26/1881*

7 AGE

Years *46*Months *8*Days *8*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *none*(c) Name of employer *none*9 BIRTHPLACE (city or town) (State or country) *Balto. Ind*10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *unknown*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *unknown*

14

Informant (Address) *Mr Hope Records*

15

Filed

MAY 5 - 1928

C. HAMPSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 4 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Aug.*, 1923, to *May*, 1928, that I last saw her alive on *May 4*, 1928, and that death occurred, on the date stated above, at *11.45 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis (unknown duration)*(duration) *10 yrs.* mos. ds.CONTRIBUTORY (Secondary) *Dementia Praecox*(duration) *20 yrs.* mos. ds.18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Bacteriological*(Signed) *Hutton P. Irel*

M. D.

, 19 (Address) *Mr Hope Records*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral*  
UNDERTAKER  
STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)*May 5 1928*  
ADDRESS

108 W. NORTH AVE.

TION is very important. See instructions on back.

E 33595

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33595

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 17-24 Ward 188-003)2-FULL NAME Hattie R. Wells(a) RESIDENCE NO. 1219 Etting

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 Color or Race

C

5 Single, Married, Widowed,  
or Divorced, (write the word)

Widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Late Wm. Wells

6 DATE OF BIRTH (month, day, and year)

Oct 22/1859

7 AGE

Years

Months

Days

68

7

10

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....

Housework

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

"

12 MAIDEN NAME OF MOTHER Ellen Johnson

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Md

14

Informant Ellen Johnson (sister)  
(Address) 1219 Etting St

15 Filed

MAY 5 1928

C. HAMPSON JONES, Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiryand that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia (Terminal)

Frac Rt. Femur-Struck by auto. at  
Dolphin & Eutaw Place Mar 9/28

(Inquest 5/4/28) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner)

M. D.

5/4/28 (Address) 503 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds.

In the

State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR

REMOVAL

Date of Burial

20 UNDERTAKER

M. D.

ADDRESS

1234

Etting St

OF DEATH in part of certificate. See instructions on back of certificate.

MAY 5 1928

E 33596

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33596

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708 Charlotte Ave. ST. 77-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Lee Boyd(a) RESIDENCE. NO. 2708 Charlotte Ave. ST. 77-44 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 3, 1928

7 AGE

Years

Months

Days

LESS than

1 day, hrs.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore Md.

10 NAME OF FATHER

Wm Lee Boyd

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Dorothy Arnold

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant

(Address)

Miss Boyd3507 Belvidere Ave

15

MAY 5 - 1928

C. HAMPSON JONES

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 4

1928

17

I HEREBY CERTIFY, That I attended deceased from

May 3, 1928, to May 4, 1928,that I last saw him alive on May 4, 1928,and that death occurred, on the date stated above, at 8:20 p. m.

The CAUSE OF DEATH\* was as follows:

Failure of Ovary's value to clear -

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. H. Berkeley, M. D., 19 (Address) 3337 Belvidere Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wt. OlmMay 5, 1928

20 UNDERTAKER

ADDRESS

Few McElley 128 E. Hart

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33597

## CERTIFICATE OF DEATH

REGISTERED NO.

33597

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *11* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Wm J English*(a) RESIDENCE NO. *305 Balto Rd Rockville Md*

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. *2* mos. *1* ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*male white married*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE *Mrs Wm J English*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min..

*5-3-4 6-5-29-1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER *Wm J English*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER *Elizabeth Offutt*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

*Hospital Records*

15 Filed

*C. HAMPTON JONES, M. D.*Per *PCW*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

*4/4*, 19 *28*, to *5/5*, 19 *28*.that I last saw him alive on *5/5*, 19 *28*.and that death occurred, on the date stated above, at *4:50* P. M.

The CAUSE OF DEATH\* was as follows:

*Pyonephrosis of left kidney*  
(duration) *4* yrs. *approx* mos. ds.

CONTRIBUTORY

(Secondary)

*gonorrhea* (duration) *2* yrs. *1* mos. ds.

15 Where was disease contracted

if not at place of death? *home*Did an operation precede death? *yes* Date of *4/10/28*Was there an autopsy? *no* *5/3/28*

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

*Smithsburg Md 7/10/28*  
*Dr. C. Hampton Jones*

OF DEATH in plain terms, so that they may be very important. See instructions on back of certificates.

5-1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33598

## CERTIFICATE OF DEATH.

100-091 E 33598

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2915 Hudson St., 17 Ward)2-FULL NAME John H. Scharf(a) RESIDENCE NO. 2915 Hudson St., 1 Ward(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days July 4<sup>th</sup> 1927  
10 9 29  
IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.10 NAME OF FATHER George W. Scharf11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Balto. Md.12 MAIDEN NAME OF MOTHER Agnes Busch13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Phila. Pa.14 Informant George W. Scharf  
(Address) 2915 Hudson St.15 1928 C. HAMPTON JONES, M. D.  
Dr. Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3<sup>rd</sup> 1928

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1928, to May 3, 1928, that I last saw him alive on May 3, 1928, and that death occurred, on the date stated above, at 5:25 p. m.

The CAUSE OF DEATH\* was as follows:  
Broncho-Pneumonia(duration) .....yrs. ....mos. 21 ds.CONTRIBUTORY Myocardial Insufficiency  
(Secondary)(duration) .....yrs. ....mos. 1 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of .....Was there an autopsy? NoWhat test confirmed diagnosis? Physical Signs(Signed) I. B. Bronushas, M. D.(Address) 3037 O'Donnell St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Sacred Heart Cem. May 7<sup>th</sup> 1928

20 UNDERTAKER

ADDRESS

Lilly & Zeiler Inc. 4038 Wagon

very important. See instructions on back of certificates.

E 33599

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 33599

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 354 WARD)2-FULL NAME Harry E. Hopkins(a) RESIDENCE NO. 1410 Eastern Ave WARD 3  
(Usual place of abode)Length of residence in city or town where death occurred 45 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.10 NAME OF FATHER William Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland12 MAIDEN NAME OF MOTHER Mary Cragen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland14 BALTIMORE CITY HOSPITALS Informant (Address) Records

15

5-1928

G. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3/1928

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1928 to May 3, 1928 that I last saw him live on May 3, 1928 and that death occurred, on the date stated above, at 9:00 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis  
myocarditis chronic  
hypertension  
arteriosclerosis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? General + Sal(Signed) C. Stelmowicz M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mount Carmel Cem.May 7, 1928

20 UNDERTAKER

Lilly & Zeller Inc

ADDRESS

403 S. Wolfe St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33600

## CERTIFICATE OF DEATH.

74-081 E 33600

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 611 So. Monroe St. 18-76 Ward)2-FULL NAME Albert F. Phillips(a) RESIDENCE NO. 1208 N. Franklin St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs.

mos. ds.

How long in U. S., if of foreign birth? yrs. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Unknown6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) Nov. 18, 18767 AGE 50 Years 5 Months 16 Days IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tool die maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Newark, N. J.10 NAME OF FATHER Jos. A. Phillips11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Eng.12 MAIDEN NAME OF MOTHER Emma J. Progan13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) England14 Informant Mrs. Mamie J. Phillips  
(Address) 1208 N. Franklin St.15 1928 C. HAMPSON JONES, M. D.  
Regist. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH May 18 192817 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Thrombosis

## CONTRIBUTORY (Secondary)

(Signed) Thos. B. Norton M. D.(Address) Curtis Bay

\*State the Disease Causing Death, and if from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Disease contracted, if not at place of death!

Former or usual residence.....

PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial 5/7-192820 UNDERTAKER H. C. Branning ADDRESS 1136 Poles Lane

OF DEATH IN THIS CERTIFICATE. See instructions on back of certificate.

E 33601

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33601

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *616 So Payson* ST. *70-28* WARD)2-FULL NAME *Edwin Louis Sanders*(a) RESIDENCE NO. *616 So Payson* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *44* yrs. mos. ds. How long in U. S., if of foreign birth? *10* yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Margaret Sanders*6 DATE OF BIRTH (month, day, and year) *May 10, 1874*7 AGE Years *53* Months *10* Days *23* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Machinist*(b) General nature of industry, business, or establishment in which employed (or employer) *Repair Machinery*(c) Name of employer *Merrill & Sons Co.*9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Edwin Sanders*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Ma Sanders*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *John Sanders* (Address) *Same address*15 *C. HAMPSON JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3, 1928*17 I HEREBY CERTIFY, That I attended deceased from *Jan 2, 1928*, to *May 3, 1928*, that I last saw him alive on *May 3, 1928*, and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*CONTRIBUTORY (Secondary) *Myocardial failure* (duration) yrs. *21* mos. ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Lab. Tests* (Signed) *Marbert C. Kitzel* M. D.19 (Address) *2151 Wilkens Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL *London Park Cemetery* DATE OF BURIAL *May 7, 1928*20 UNDERTAKER *George L. Schwab* ADDRESS *4401 Buckle*

TION is very important. See instructions on back of certificate.



33602

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 33602

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 Laretta Ave. 129-69)

2-FULL NAME Mary A. Culleton

(a) RESIDENCE NO. 2405 Laretta Ave.

(Usual place of abode)  
Length of residence in city or town where death occurred. Life yrs.

mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

John L. Culleton

6 DATE OF BIRTH (month, day, and year) Feb. 8, 1856

7 AGE

Years

Months

15 Days

If LESS than  
1 day, hrs.  
or min.

72

2

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work at

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md.

10 NAME OF FATHER

Michael Callahan

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary McGuade

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ireland

14

Informant  
(Address)Mrs. Sadie McPhee  
2405 Laretta Ave.

5-1928

File

C19 HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Apr. 23, 1928, to May 3, 1928,  
that I last saw her alive on May 3, 1928,  
and that death occurred, on the date stated above, at 3:25 p. m.  
The CAUSE OF DEATH\* was as follows:

Bronchitis Pneumonia

(duration) yrs. mos. 13 ds.  
CONTRIBUTORY (Secondary) Initial Pneumonia  
(duration) yrs. 6 mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alice L. Culleton, M. D.

19 (Address) 1038 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery May 2, 1928

20 UNDERTAKER

Elmer W. Conklin 624 E. Eager

E 33603

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33603

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1148 E North Ave* ST. *13-59* WARD)2-FULL NAME *Constance E Meyers*(a) RESIDENCE No. *1148 E North Ave* ST. *13-59* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *52* yrs. mos. ds.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word) *Widow**Female**White*5a If married, widowed, or divorced HUSBAND of or) WIFE of *George L Meyers*6 DATE OF BIRTH (month, day, and year) *Aug 24 1853*

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

*74**8**10*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *New York N. Y.*10 NAME OF FATHER *A. P. Marconies*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *France*12 MAIDEN NAME OF MOTHER *Josephine L. Piery*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *France*

14

Informant *George L Meyers*  
(Address) *1148 E North Ave*

15

Filed *1928*G. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 4<sup>th</sup> 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 30, 1928* to *May 4, 1928*.that I last saw her alive on *May 4, 1928*.and that death occurred, on the date stated above, at *1.15 PM* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency  
Chr. Myocarditis -  
Myocardial Insufficiency*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Harry H. H.*, M. D.5/4, 1928 (Address) *1100 E North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Cemetery**May 7 1928*

20 UNDERTAKER

ADDRESS

*George Schilling & Sons**126 E. Monument St.*

E 33604

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33604

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 N. Charles ST. 11-24 WARD)2-FULL NAME Mary Amelia Ballantyne(a) RESIDENCE NO. 1204 N. Charles ST. 11-24 WARD(Usual place of abode)  
Length of residence in city or town where death occurred 40 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced Widow Hamilton  
HUSBAND or or) WIFE of Ballantyne6 DATE OF BIRTH (month, day, and year) Sept 28 18677 AGE 61 Years 7 Months 18 Days 12 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At wife -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick, Md.  
(State or country)10 NAME OF FATHER Henry Yeable11 BIRTHPLACE OF FATHER (city or town) Frederick, Md.  
(State or country)12 MAIDEN NAME OF MOTHER Mary Yeable13 BIRTHPLACE OF MOTHER (city or town) Frederick  
(State or country)14 Informant Daughter  
(Address)15 1928 FILED 19 HAMMOND JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 192817 I HEREBY CERTIFY, That I attended deceased from Feb 20th, 1927, to May 5th, 1928, that I last saw her alive on May 5th, 1928, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis, Infective Arthritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur C. Monmouth, M.D.5, 5, 1928 (Address) 323 E North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cemetery May 8 1928

20 UNDERTAKER

ADDRESS

H. W. Means & Son 805 N. Calvert

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33605

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3203 W. North Ave. ST. 15-67 WARD)2. FULL NAME Harwell Waters Thomas(a) RESIDENCE No. 3203 W. North Ave. ST. WARDLength of residence in city or town where death occurred 42 yrs. 10 mos. 22 ds.E 33605  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leona Thomas6 DATE OF BIRTH (month, day, and year) July 25-18857 AGE Years 42 Months 10 Days 22 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder(b) General nature of industry, business, or establishment in which employed (or employer) Vice Pres and Gen'l Mgr.(c) Name of employer Maryland Realty Corp.9 BIRTHPLACE (city or town) (State or country) Baltimore Md.10 NAME OF FATHER Joseph Thomas11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Michael's Md.12 MAIDEN NAME OF MOTHER Eleanor Bladen13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Michael's Md.14 Informant Charles E. Ederkin (Address) 20 E. Franklin St.15 Filed 1928 C. HAMPTON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 192817 I HEREBY CERTIFY, that I attended deceased from April 29, 1928, to May 3, 1928, that I last saw him alive on May 3, 1928, and that death occurred, on the date stated above, at 10:10 p. m.THE CAUSE OF DEATH was as follows: Chronic Valvular Heart-diseaseCONTRIBUTORY (Secondary) Chronic interstitial nephritis (duration) 2 yrs. - mos. - ds.18 Where was disease contracted if not at place of death? at homeDid an operation precede death? No Date of -Was there an autopsy? NoWhat test confirmed diagnosis? Lat. test (Signed) W. Hoffman M. D.19 (Address) 8 East Bond St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Woodlawn CemeteryDATE OF BURIAL May 7 1928ADDRESS Chesapeake & AtlanticDERTAKER Henry Jenkins & Son



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33606

CERTIFICATE OF DEATH

E 33606

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2307 W. North Ave. ST. 15-68 WARD 57)

2—FULL NAME

Bernard Feit

(a) RESIDENCE NO.

2307 W. North ST. WARD 57

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State) How long in U. S. if foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Feit

DATE OF BIRTH (month, day, and year) unknown

AGE Years 73 Months — Days — If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Anton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. Feit (Address) 2307 W. North Ave.

FILED 6-1928 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/28

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1926 to May 4, 1928, that I last saw him alive on May 4, 1928 and that death occurred, on the date stated above, at 1 PM. m. The CAUSE OF DEATH\* was as follows:

Atherosclerosis

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) 2 yrs. mos. ds. Diabetes Mell. (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) Eugene J. Leppard, M. D.

, 19 (Address) 230 W. Lafayette Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Hebrew Herron Rm DATE OF BURIAL 5/4 1928

20 UNDERTAKER Josh Lewis 1439 E. Balto St ADDRESS

E 33607 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH *Nehren aged Home*

CITY OF BALTIMORE; (No. *Belvedere Greening St.* WARD)

2—FULL NAME *Charles Herman*

(a) RESIDENCE NO. *Belvedere Greening St.* WARD

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred *6* yrs. mos. ds. How long in U. S., If foreign birth *2* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

a If married, widowed, or divorced HUSBAND of (or) WIFE of *Unknown*

DATE OF BIRTH (month, day, and year) *Aug 15 1843*

AGE Years *85* Months *—* Days *—* If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *old age*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14 Informant *Bertie C. Herman* (Address) *2042 Edmond St.*

15 Filed *Y 6-1928* *C. HAMPSON JONES* Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/5/28*

17 I HEREBY CERTIFY, That I attended deceased from *April 15*, 1928, to *May 4*, 1928, that I last saw him alive on *May 4*, 1928, and that death occurred, on the date stated above, at *2 a* m.

The CAUSE OF DEATH\* was as follows:

*Arterio sclerosis and chronic Myocarditis* (duration) *3-4* yrs. mos. ds.

CONTRIBUTORY (Secondary) *none*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Herman Seidel*, M. D. *5/5*, 1928 (Address) *2494 Eutaw Pl*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

*Nehren Nehren Rd* *5/6* 1928

20 UNDERTAKER *Jack Lewis 1439 E B St*

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33608

## CERTIFICATE OF DEATH

129 E 33608

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2027 E. Fairmount Ave 6-9 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 2027 E. Fairmount Ave 6-9 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 4 mos. 4 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 84 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Schleupner

## 6 DATE OF BIRTH (month, day, and year)

Dec. 30 1852

## 7 AGE

Years

Months

Days

IF LESS than  
1 day...hra.  
or...min..

75

4

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Tailor

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore, Md

## 10 NAME OF FATHER

John Schleupner

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Anna Donhardt

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant

(Address)

John G. Schleupner  
2247 E. Baltimore St

## 15 Filed

C. H. HANCOCK JONES, M. D.

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

## 17

I HEREBY CERTIFY, That I attended deceased from

April 25, 1928, to May 2, 1928,

that I last saw him alive on May 2, 1928,

and that death occurred, on the date stated above, at 7<sup>45</sup> P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) 3 yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

Nephritis (duration) one yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical &amp; Laboratory Exam

(Signed) Albert Jaffe, M. D.

1928 (Address) 208 E. Fairmount Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Holy Redeemer Cemetery May 7 1928

## 20 UNDERTAKER

ADDRESS

Henry Hockes Son 1301 E. Eager

very important. See instructions on back of certificates.

AY 6-1928

E 33609

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33609

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3818 Kate Ave. ST. 15-63 WARD)2-FULL NAME Mary Keatts Wheeler(a) RESIDENCE NO. 3818 Kate Ave ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of \_\_\_\_\_ or WIFE of Thomas R. Wheeler6 DATE OF BIRTH (month, day, and year) Nov. 23, 1856

7 AGE

Years 71Months 5Days 11

If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None.

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) Va.10 NAME OF FATHER Wm. Oliver Hamilton11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) Balt. Md.12 MAIDEN NAME OF MOTHER Susan F. Reeves13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) Va.

14

Informant (Address) Miss Annie L. Hamilton  
3818 Kate Ave.

15

MAY 6 - 1928

HAMPSON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1928

17

I HEREBY CERTIFY, That I attended deceased from April 9th, 1928, to May 4th, 1928that I last saw her alive on May 4th, 1928, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH\* was as follows:

Pyelitis - Septicemia - Senility -

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) Cardio-vascularCollapse

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Clinical exam(Signed) Wm. B. Jones M. D.  
4/5, 1928 (Address) 3818 Kate Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL St. Oliver Cem. PaulistownDATE OF BURIAL May 7, 2820 UNDERTAKER Wm. J. Dickner SonsADDRESS North & Pa



## E 33610 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33610

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3608 Clifton Ave ST. 5-61 WARD)2-FULL NAME Arintia A. Dougherty(a) RESIDENCE No. 3608 Clifton Ave ST. 5-61 WARD(Usual place of abode)  
Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, year) Apr. 1st 18617 AGE Years 67 Months 1 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Crisfield  
(State or country) Md10 NAME OF FATHER Joseph Byrd11 BIRTHPLACE OF FATHER (city or town) Crisfield  
(State or country) Md12 MAIDEN NAME OF MOTHER Ann E. Sterling13 BIRTHPLACE OF MOTHER (city or town) Crisfield  
(State or country) Md14 Informant Richard H. Dougherty  
(Address) 3608 Clifton Ave

15 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 192817 I HEREBY CERTIFY, That I attended deceased from Mar-10, 1928, to May-4, 1928, that I last saw her alive on Apr 27, 1928, and that death occurred, on the date stated above, at 4 A.M.The CAUSE OF DEATH\* was as follows:  
Myocardial insufficiency  
dysrhythmia, and decompensation.  
Chronic valvular disease  
Mitral. (duration) 7 yrs. 0 mos. 0 ds.  
CONTRIBUTORY decompensation, cardiac  
(Secondary) (duration) 2 yrs. 0 mos. 0 ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Galt, M. D.Address 2207 Harrison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lorraine

DATE OF BURIAL

May 7 1928

20 UNDERTAKER

W. J. Dickner & Sons

ADDRESS

North & Palmyra

E 33611

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33611

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5303 Melvin Ave. 7-55 WARD)

### 2-FULL NAME

Elisabeth Madal Fox

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 5303 Melvin Ave. SE, WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Fox

6 DATE OF BIRTH (month, day, and year) Apr. 5, 1865

7 AGE Years 63 Months 0 Days 29 If LESS than 1 day, hrs or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Portsmouth (State or country) Va

10 NAME OF FATHER ? Brant

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Mr. John C. Fox (Address) 5303 Melvin Ave.

15 Filed 1928 HAMER JONES, M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1928

17 I HEREBY CERTIFY, That I attended deceased from July 27- 1928, to May 4, 1928, that I last saw him alive on May 4, 1928, and that death occurred, on the date stated above, at 5.35 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X ray (Signed) Chas. J. Keller, M. D.

5/5, 1928 (Address) 222 W. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Cem.

May 7 1928

20 UNDERTAKER

ADDRESS

W. H. Hickner Sons

North Pa

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33612

E 33612

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* 15-61 WARD)2-FULL NAME *Mrs Ella May Meeks*(a) RESIDENCE NO. *2113 Chelsea Terrace* ST.

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. — mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced *HUSBAND* of *John Andrew Meeks* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Jan. 11, 1877*7 AGE Years *51* Months *3* Days *23* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *Robert Joe*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Emma Largent*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*14 Informant *Mr. John A. Meeks* (Address) *2113 Chelsea Terrace*15 *1928* *C. H. JONES, M. D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 4 1928*17 I HEREBY CERTIFY, That I attended deceased from *Apr. 30*, 1928, to *May 4*, 1928, that I last saw her alive on *May 4*, 1928, and that death occurred, on the date stated above, at *4:50 P.* m.

The CAUSE OF DEATH\* was as follows:

*Diabetes Mellitus (Diabetic coma)*(duration) *10* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *NO* Date ofWas there an autopsy? *NO*What test confirmed diagnosis? *Clinical*(Signed) *Service Elda T. Taylor, M. D.*19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Horroine Cem.*

DATE OF BURIAL

*May 7, 1928*

20 UNDERTAKER

*Wm. J. Meekins Sons*

ADDRESS

*North*

E 33613

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33613

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 604 N. Dallas St., 7-9 Ward)2-FULL NAME Florence Collins(a) RESIDENCE NO. 604 N. Dallas St., 7-9 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs.

mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Collins6 DATE OF BIRTH (month, day, and year) March 30 18807 AGE Years 48 Months 1 Days 5

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (city or town) md  
(State or country)12 MAIDEN NAME OF MOTHER Marrett Cooper13 BIRTHPLACE OF MOTHER (city or town) md  
(State or country)14 Informant Mary E Brown  
(Address) 604 N. Dallas St15 Filed..... 19 28 C. H. HARRISON Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 192817 I HEREBY CERTIFY, That I attended deceased from April 21, 1928, to May 4, 1928, that I last saw him alive on May 4, 1928, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH\* was as follows:

Valvular heart diseaseIntermittent (duration) ..... yrs. .... mos. .... ds.acute asthmatic attack

(Secondary)

about a hour (duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of.....Was there an autopsy? noWhat test confirmed diagnosis? ✓(Signed) J. Edward Fisher, M. D.(Address) 162 E Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Asbury Cemetery5-7-1928

20 UNDERTAKER

Mrs. Lakes G. Bailey 1421 Jefferson

very important. See instructions on back of certificate.

MAY 6 - 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33614

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 Darley Ave St. 8-45 Ward)

2-FULL NAME Franklin D. Lauman

(a) RESIDENCE NO. 1209 Darley Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19/28

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min. 2 15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md. (State or country)

10 NAME OF FATHER Teddy Lauman

11 BIRTHPLACE OF FATHER (city or town) Balto., Md. (State or country)

12 MAIDEN NAME OF MOTHER Ollie Dixon

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mother (Address)

15 Filed C. HARRISON JONES, M. D. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.)

inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidental Suffocation in Crib.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. J. Herr (Coroner) M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL 5/5/28 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Oak Lawn Cem May 6 1928

20 UNDERTAKER Jos. J. Herr 156 N. Luzerne

very important. See instructions on back of certificate.

33615

# HEALTH DEPARTMENT—CITY OF BALTIMORE

33615

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17-24 ST. 17-24 WARD)

BALTIMORE CITY HOSPITALS

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

James P. Payne

### (a) RESIDENCE No.

924 D. and Lee Ave.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 42 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

male

#### 4 COLOR OR RACE

colored

#### 5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of or WIFE of

Hettie Payne

#### 6 DATE OF BIRTH (month, day, and year)

Jun 6. 1886

#### 7 AGE

Years

Months

Days

42

3

27

If LESS than 1 day, hrs. or min.

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

#### 10 NAME OF FATHER

James P. Payne

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

#### 12 MAIDEN NAME OF MOTHER

J. A. Adams

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

#### 14

Informant (Address)

Records

MAY 6 - 1928

C. HARRISON JONES, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3/1928

17

I HEREBY CERTIFY, That I attended deceased from

April 10, 1928 to May 3, 1928

that I last saw him live on May 3, 1928

and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH\* was as follows:

Acute myocardial infarction  
myocarditis chronic & acute  
suppurative

(duration) 1 yrs. mos. ds.

#### CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Sub

(Signed) C. Harrison Jones M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Zion

#### 20 UNDERTAKER

Joseph A. Lynch

#### DATE OF BURIAL

May 8 1928

409 N. Mount

# E 33616 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 W. Montgomery ST. 22-30 WARD)

### 2-FULL NAME

William Smith

### (a) RESIDENCE NO.

610 W. Montgomery ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

— yrs.

8 mos.

5 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug-30-1927

7 AGE

Years

Months

Days

If LESS than 1 day,.....hrs. or.....min.

—

8

5

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

August

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore  
Maryland

10 NAME OF FATHER

Clarence C. Smith

11 BIRTHPLACE OF FATHER (city or town)

Baltimore  
Maryland

12 MAIDEN NAME OF MOTHER

Mrs. M. J. Pearce

13 BIRTHPLACE OF MOTHER (city or town)

Stevensville  
Maryland

14

Informant

(Address)

Nattie Nicholson  
610 W. Montgomery

15

MAY 6 - 1928 H. J. JONES Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/4 1928

17

I HEREBY CERTIFY, That I attended deceased from

4/24, 1928, to 5/4, 1928.

that I last saw him alive on

5/4, 1928.

and that death occurred, on the date stated above, at 1130 m.

The CAUSE OF DEATH\* was as follows:

Acute Broncho  
Pneumonia  
(Primary)

(duration) — yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Daw Drancher, M. D.

5/5, 1928 (Address) 122 W. Lee St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mount Auburn May 7 1928

20 UNDERTAKER

ADDRESS

Joseph A. Lively 489 N. Mount

E 33617

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Provident Hospital* St. *111* Ward *111*)

## 2-FULL NAME

(a) RESIDENCE NO. *111 Vincent St.* St. *111* Ward *111*

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 Color or Race

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Oct 18, 1892

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

6 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md

10 NAME OF FATHER

John Henry Francis

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Ct Md

12 MAIDEN NAME OF MOTHER

Nettie Louise

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ct Md

14

Informant (Address)

John Henry Francis 111 Vincent St

15 Filed

19

MAY 6 - 1928

C. HAMPSON JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

May 4 28

17

I HEREBY CERTIFY, That I attended deceased from

Apr 21, 1928, to May 4, 1928,

that I last saw her alive on May 4, 1928,

and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

, 19

(Address)

Physician's Signature  
John C. Sainey, M. D.  
Provident Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mount Zion

5-7 1928

19 UNDERTAKER

ADDRESS

Joseph A. Lynch 409 Mount Zion



E 33618

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *1-30*)

## 2. FULL NAME

*William H. Long (or Tangle)*

## (a) RESIDENCE NO.

*Jones station, A. A. C. WARD*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

*18* ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Widowed*

## 6 DATE OF BIRTH (month, day, and year)

*unknown*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*83*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Long Island*

## 10 NAME OF FATHER

*unknown*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*unknown*

## 12 MAIDEN NAME OF MOTHER

*unknown*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*unknown*

## 14

Informant (Address)

*Hospital record*

## 15

Filed

6-1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*5/5/28* 19

## 17

I HEREBY CERTIFY, That I attended deceased from

*4/17/28* 19 to *5/5/28* 19that I last saw him alive on *5/5/28* 19and that death occurred, on the date stated above, at *9:15 A.M.*

The CAUSE OF DEATH\* was as follows:

*Generalized arteriosclerosis  
Coronary arteriosclerosis**unknown* (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Bronchopneumonia*(duration) yrs. mos. *4* ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Clinical autopsy*

(Signed)

*J. F. Lusk* M. D.

19

(Address)

*University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Cremation**Md.*

## DATE OF BURIAL

*5/5/28*

## 20 UNDERTAKER

*Jos. L. Tangle. 2 Sons Annapolis*

## ADDRESS

E 33619

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33619

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5013 York Rd.*)ST. *27-48* WARD

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*John C. Raper*(a) RESIDENCE NO. *5013 York Rd.*

(Usual place of abode)

ST., \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced. (write the word)

*Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*

6 DATE OF BIRTH (month, day, and year)

*Oct 1-1848*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*79**7**4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Real Estate*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Retired*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*John C. Raper*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Margaret E. Brockway*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Chas. Raper 5013 York Rd.*

15

Filed

19

*C. THOMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 5 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 29, 1928, to May 5, 1928.*that I last saw him alive on *May 4, 1928.*and that death occurred, on the date stated above, at *3<sup>25</sup> m.*

The CAUSE OF DEATH\* was as follows:

*Double Pneumonia (Labor)*(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

*Bright's Disease*(duration) *3* yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of —Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *E. H. Duncan* M. D., 19 (Address) *5106 York Road*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Presbyterian Church**May 7 1928*

20 UNDERTAKER

ADDRESS

*Wm. Booth 507 E. North Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33620

## CERTIFICATE OF DEATH.

E 33620

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

48 yrs.

mos.

ds.

ST.,

WARD

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Sept 17 1879

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48

7

17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

August Hartung

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Berrie Burkhardt

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

Jno Hartung  
1439 Hull St

## 15

Filed

MAY 6 - 1928

HAMILSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 4 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Apr 2, 1928, to May 4, 1928.

that I last saw him alive on

May 3, 1928.

and that death occurred, on the date stated above, at

5:30 a.m.

The CAUSE OF DEATH\* was as follows:

Shock Coma

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Thos S. Larens, M. D.

5/5, 1928 (Address)

2575 Harbor Park

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

London Park

May 7, 1928

## 20 UNDERTAKER

ADDRESS

Chas. S. Larens

1501 1st St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33621

## CERTIFICATE OF DEATH.

90 E 33621

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 Mt Royal Ave ST. 11-70 WARD)2-FULL NAME Maria Henrietta Huddleton(a) RESIDENCE NO. 1329 Mt Royal Ave ST. 11-70 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 00 mos. 00 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23<sup>rd</sup> 18417 AGE Years 87 Months 00 Days 15 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina10 NAME OF FATHER John Izard Huddleton11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston South Carolina12 MAIDEN NAME OF MOTHER Sarah Weston13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston South Carolina14 Informant Miss M. Huddleton (Address) 1329 Mt Royal Ave15 Filed 6-19-28 19 FLAHERTY JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1928, to May 5<sup>th</sup>, 1928.that I last saw her alive on May 4<sup>th</sup>, 1928.and that death occurred, on the date stated above, at 1230 A. M.

The CAUSE OF DEATH\* was as follows:

Arterio-Sclerosis -(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary)

hypertension (duration) yrs. mos. ds. 17

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Chas W. Carroll M. D.May 5<sup>th</sup> 1928 (Address) 1327 Mt Air

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

GREENMOUNT CEM

20 UNDERTAKER

H. W. JENKINS. SON. CO

DATE OF BURIAL

5-7 1928

ADDRESS

ORCHARD McCALLAN



E 33622

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33622

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Stricker

ST. 19-28 WARD)

## 2-FULL NAME

John Bullock

(a) RESIDENCE No. 119 S. Stricker

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)  
Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1860

7 AGE

Years 67

Months 5

Days 14

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Clerk(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer Baltimore Post Office

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

10 NAME OF FATHER Joseph L. Bullock

11 BIRTHPLACE OF FATHER (city or town) Philadelphia

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna H. Meyer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Miss Rhoda L. Bullock

(Address) 119 S. Stricker St.

15

Filed

G. HAMPTON JONES, M.D. Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
Apr 12, 19 28 to May 4, 19 28.  
that I last saw him alive on May 4, 19 28,  
and that death occurred, on the date stated above, at 11.15 A. m.  
The CAUSE OF DEATH\* was as follows:

Cardiac Dilatation

(duration) yrs. mos. ds. 7

CONTRIBUTORY  
(Secondary) Myocarditis

(duration) yrs. mos. ds. 1

18 Where was disease contracted  
if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. H. Bullock

4/4, 1928 (Address) 216 E. University Pkwy. M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Loudon Park Cemetery

UNDERTAKER

## DATE OF BURIAL

May 7 19 28

ADDRESS

1003 West  
Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33623

## CERTIFICATE OF DEATH

E 33623

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3405 Carlisle Ave. St. 15-61 Ward)

## 2-FULL NAME

Augusta Rudolphi

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

3405 Carlisle Ave. St. 15-61 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S. if of foreign birth? 63 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female white Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

May 28, 1864

## 7 AGE

Years

Months

Days

IF LESS than 1 day...hrs. or...min..

63116

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

md

## 10 NAME OF FATHER

Charles Rudolphi

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Bredericka Gunther

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant (Address)

Miss Katie Rudolphi  
3405 Carlisle Ave.

## 15 Filed

C. H. JONES, M. D.  
Register

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

May 4, 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 1927, to May 4, 1928.that I last saw her alive on May 13, 1928.and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 4 yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

Cardiac Asthenia

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Operation & examination(Signed) W. H. Jones M. D.19 (Address) 3429 Ches. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## Date of Burial

London Park CemeteryMay 7, 1928

## 20 UNDERTAKER

## ADDRESS

Jo S. Janssens & Son27 S. Paca St.

very important. See instructions on back of certificates.

PARENTS

Y 6-1928

013218  
E 33624

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

✓33624

\*100-001  
E 33624

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL* ST., *7-9* WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

*Ernest A. Fitter*

### (a) RESIDENCE NO.

*Levy Jefferson Ave - ST.,*

### WARD

*Brooklyn N.Y.*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *19* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

*Male*

#### 4 COLOR OR RACE

*White*

#### 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

#### 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

*2 2 1846*

#### 7 AGE

*42*

Years

Months

Days

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

#### (a) Trade, profession or particular kind of work.

*Commission Merchant*

#### (b) General nature of industry, business, or establishment in which employed (or employer)

*045*

#### (c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

*Germany*

#### 10 NAME OF FATHER

*Christopher Fitter*

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ger -*

#### 12 MAIDEN NAME OF MOTHER

*Hedwisch Mangels*

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ger -*

#### 14

Informant (Address)

*Records -*

#### 15

Filed

19

*C. H. JONES, M. D.*

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

*May 6 1928*

#### 17

I HEREBY CERTIFY, That I attended deceased from

*April 17 1928, to May 6 1928,*

that I last saw him alive on *May 6 1928,*

and that death occurred, on the date stated above, at *10 19 a.m.*

#### The CAUSE OF DEATH\* was as follows:

*Blunt Perforating Hypertension*

(duration) *3* yrs. mos. ds.

#### CONTRIBUTORY (Secondary)

*Branch Pneumonia*

(duration) yrs. mos. *3* ds.

#### 18 Where was disease contracted

if not at place of death?

*N. Y.*

#### Did an operation precede death?

*Yes* Date of *April 27-28*

#### Was there an autopsy?

*No*

#### What test confirmed diagnosis?

*Clinical*

(Signed)

*Robert W. Moxley M. D.*

, 19

(Address)

*4. H. H.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Brooklyn N.Y.*

#### UNDERTAKER

*Hughes & Jones Inc*

#### DATE OF BURIAL

*5/6/28 19*

#### ADDRESS

*4-14 N Broadway*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33625

## CERTIFICATE OF DEATH

46 E 33625

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Belt

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa M. Tucker.(a) RESIDENCE NO. 1615 Belt

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred 6 yrs.  mos.  ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced, (write the word) Widowed.If married, widowed, or divorced, HUSBAND of the late, William Tucker. (or) WIFE ofDATE OF BIRTH (month, day, and year) Jan. 2, 1857.AGE Years 71, Months 4, Days 2. If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Frederick Co Md. (State or country)10 NAME OF FATHER John Smith.11 BIRTHPLACE OF FATHER (city or town) Frederick Co. Md. (State or country)12 MAIDEN NAME OF MOTHER Christiana Rhodes.13 BIRTHPLACE OF MOTHER (city or town) Frederick Co Md. (State or country)14 Informant Mrs. Bertha Eversman. (Address) 1615 Belt St.15 Filed 1928 HAMMON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-2817 I HEREBY CERTIFY, That I attended deceased from About 15 years, 19 5-4-28, 19 that I last saw her alive on 5-4-28, 19  and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH\* was as follows:

Uterine Carcinoma(duration) 1 yrs.  mos.  ds.

CONTRIBUTORY (Secondary)

(duration)  yrs.  mos.  ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Clinical - Microscope(Signed) Philip B. Fowler M. D.5-5-28 19 (Address) 1432 William St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Cedar Hill Cem DATE OF BURIAL May 6, 192820 UNDERTAKER A. Edward EvansADDRESS 1432 William St



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33626

## CERTIFICATE OF DEATH.

90 E 33626

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore City Hospital 74-33* ST. WARD)

2. FULL NAME *Georgiana Day*

(a) RESIDENCE NO. *30 E Fort Ave* ST.

(Usual place of abode)  
Length of residence in city or town where death occurred *50* yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 26 1857*

7 AGE Years *76* Months *10* Days *9* If LESS than 1 day. hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Va -*

10 NAME OF FATHER *John Day*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va -*

12 MAIDEN NAME OF MOTHER *Nancy Lee Bennett*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va -*

14 Informant (Address) *My Laura Hillman 30 E Fort Ave*

15 Filed *7-1928* REGISTRAR *HAMMON JONES, M. D.* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-5-1928*

17 I HEREBY CERTIFY, That I attended deceased from *2-28-1928* to *5-5-1928*

that I last saw him alive on *5-5-1928* and that death occurred, on the date stated above, at *8:15* m.

The CAUSE OF DEATH\* was as follows:

*Generalized Atherosclerosis  
Coronary Myocarditis*

CONTRIBUTORY (Secondary) *Branchitis*

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Physician's*

(Signed) *W. Howard Evans, M. D.*  
(Address) *Baltimore City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Baltimore* DATE OF BURIAL *May 7 1928*

20 UNDERTAKER *W. Howard Evans 38 E Fort Ave* ADDRESS

33627

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

129 E 33627

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 S. Charles

ST. 11-70 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Carter

(a) RESIDENCE NO. 1427 S. Charles

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 11 mos. 24

How long in U. S., if foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female. White. Married.

If married, widowed, or divorced

HUSBAND of George W. Carter.  
(or) WIFE of

DATE OF BIRTH (month, day, and year) May, 11, 1868.

AGE Years Months Days If LESS than 1 day, hrs. or min.  
59, 11, 24.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Calvert Co. Md.  
(State or country)

10 NAME OF FATHER William Johnson.

11 BIRTHPLACE OF FATHER (city or town) Calvert Co.  
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. Md.  
(State or country)14 Informant Mrs. Margaret Trott.  
(Address) 1427 S. Charles St.15 Filed 1928 HAYDEN JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5.5.28.

17

I HEREBY CERTIFY, That I attended deceased from about 12 yrs. 19 to 5.5.28.

that I last saw her alive on 5.5.28.

and that death occurred, on the date stated above, at 5.30 P. M.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

(duration) 12 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical-Clinical. Triangles

(Signed)

Philip B. Tauler, M. D.

5.6.28 (Address) 1432 William St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33628

## CERTIFICATE OF DEATH.

90 E 33628  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 306 E 32 St St. 12-50 Ward)2-FULL NAME Arthur H. Craig(a) RESIDENCE NO. 306 - E. 32 St St. \_\_\_\_\_ Ward \_\_\_\_\_Length of residence in city or town where death occurred 18 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of Sarah K. Craig6 DATE OF BIRTH (month, day, and year) 3-15-777 AGE Years Months Days IF LESS than  
51 1 19 1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Ill.10 NAME OF FATHER J. Craig11 BIRTHPLACE OF FATHER (city or town) Mass  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Ill.  
(State or country)14 Informant Sarah K. Craig  
(Address) 306 E. 32 St15 Filed 1928 19 11 AM Registrar R. H. K.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4 192 817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Saboulay Hernan  
of Heart  
(duration) ..... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

(Signed) J. H. H. H. M. D.  
(Coroner)5/6, 1928 (Address) 3672 Rolandon

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Roaden Park Cemetery Date of Burial May 7 1928

## 20 UNDERTAKER

Harry H. Amacost ADDRESS 4204 Ridgewood Ave

very important. See instructions on back of certificate.

33629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33629

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3021 Belmont Ave.* ST. *16-67* WARD)

2. FULL NAME

*Bernard Kinsley*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *3021 Belmont Ave.* ST. WARD

Length of residence in city or town where death occurred *72* yrs. *9* mos. *14* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widower*

5a If married, widowed, or divorced HUSBAND of or WIFE of *Lucy M. Kinsley*

6 DATE OF BIRTH (month, day, and year) *July 15, 1855*

7 AGE Years *72* Months *9* Days *14* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Meat salesman*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*

10 NAME OF FATHER *Bernard Kinsley*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Albany N.Y.*

12 MAIDEN NAME OF MOTHER *Matilda Gale*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Merchantsville N.J.*

14 Informant (Address) *Hazel M. Brophy 3021 Belmont Ave.*

15 *Y 7-1928* *C. HAMMON JONES, M.D.* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 5, 1928*

17 I HEREBY CERTIFY, That I attended deceased from *May 3, 1928*, to *May 5, 1928*, that I last saw him alive on *May 3, 1928*, and that death occurred, on the date stated above, at *1.15 p.m.* The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

CONTRIBUTORY (Secondary) *hypertension* (duration) *10* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical*

(Signed) *J. & Zierler* M.D. (Address) *701 Medical Arts Bldg*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

*Greenmount Cemetery May 8, 1928*

20 UNDERTAKER

ADDRESS

*Jos. Syfer 1600 N. North Ave.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33630

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 33630

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Provident Hosp* St. *19-27* Ward *1*)

## 2-FULL NAME

*Hilda Cook*

## (a) RESIDENCE NO.

*1516 W Saratoga*

(Usual place of abode)

Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *21* yrs. *11* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *Cauc* 5 Single, Married, Widowed, or Divorced. (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Child*

6 DATE OF BIRTH (month, day, and year)

*Jan 10 - 1925*

7 AGE

Year

Months

Days

IF LESS than 1 day.....hrs. or.....min.

*2 10 24*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

*Baltimore, Md*

(State or country)

## 10 NAME OF FATHER

*Eliza Cook*

## 11 BIRTHPLACE OF FATHER (city or town)

*L. B.*

(State or country)

## 12 MAIDEN NAME OF MOTHER

*May Taler*

## 13 BIRTHPLACE OF MOTHER (city or town)

*L. B.*

(State or country)

## 14

Informant (Address)

*Eliza Cook 1516 W Saratoga*

## 15 Filed

*7-1928**HAMMOND JONES, M. D.*

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) *May 4* 192*8*17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said *Inquest* (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(duration) .....yrs. ....mos. *one*

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signature)

*F. B. Cook* M. D.

(Address)

*Baltimore*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*MT Auburn Cem*

## 20 UNDERTAKER

*Demetrius Carter*

Date of Burial

*5/7 - 1928*

ADDRESS

*916 Be me*

E 33631

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 E 33631

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sinai Hospital* ST. *19-28* WARD)2-FULL NAME *Alexander Miller*(a) RESIDENCE NO. *1523 Cole*

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. — mos. — ds.

ST. — WARD —

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? *75* yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Theresa Birch*6 DATE OF BIRTH (month, day, and year) *March*

7 AGE

Years

Months

Days

If LESS than  
1 day, — hrs.  
or — min.*59*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Presser Tailoring*9 BIRTHPLACE (city or town)  
(State or country)*Russia*

10 NAME OF FATHER

*Unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Unknown*

14

Informant  
(Address)*Theresa Miller  
1523 Cole St*

15

Filed

7-1928

G. H. HAMMON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/4* 19 *28*

17

HEREBY CERTIFY, That I attended deceased from *April 5*, 19 *28*, to *May 4*, 19 *28*,  
that I last saw him alive on *May 4*, 19 *28*,  
and that death occurred, on the date stated above, at *3:30 P.* m.

The CAUSE OF DEATH\* was as follows:

*Bilateral Broncho-Pneumonia*(duration) yrs. mos. *7* ds.CONTRIBUTORY (Secondary) *Hypertension of Kidney with Metastases* (duration) *4* yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Metastases in Lung, Liver, etc.*(Signed) *M. D. Jones* M. D.5/5, 19 *28* (Address) *Sinai Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Balto Hebrew Cemetery* *May 7* 19 *28*

20 UNDERTAKER

ADDRESS *1127**Edwinson* *Bo E Balto St*

# Reuben Hengst

## HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 33632****CERTIFICATE OF DEATH.**90  
15-66  
**REGISTERED NO.****E 33632****1-PLACE OF DEATH****CITY OF BALTIMORE:** (No. 2128 Mt HollyST. 15-66 WARD)**2-FULL NAME** Reuben Hengst,**(a) RESIDENCE NO.** 2128 Mt Holly

(Usual place of abode)

ST. 15-66 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced, (write the word) <u>Widowed</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Charlotte A. Hengst,

6 DATE OF BIRTH (month, day, and year) October 26, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>92</u>	<u>6</u>	<u>9</u>	

**8 OCCUPATION OF DECEASED**(a) Trade, profession or particular kind of work Retired Grocery(b) General nature of industry, business, or establishment in which employed (or employer) Merchant(c) Name of employer Himself9 BIRTHPLACE (city or town) York Co. Pennsylvania  
(State or country)10 NAME OF FATHER Samuel Hengst.11 BIRTHPLACE OF FATHER (city or town) Pennsylvania  
(State or country)12 MAIDEN NAME OF MOTHER Anstine.13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania  
(State or country)14 Informant Mrs Charles E. Sammis  
(Address) 2128 Mt Holly St.15 Filed 1928 C. HAMPTON JONES, M. D.  
Per Reg Registrar**MEDICAL CERTIFICATE OF DEATH**16 DATE OF DEATH (month, day, and year) May 5, 1928

17 I HEREBY CERTIFY, That I attended deceased from  
Dec - 20, 1927 to May 5, 1928,  
that I last saw him alive on May 5, 1928,  
and that death occurred, on the date stated above, at 9-8 m.

The CAUSE OF DEATH\* was as follows:  
Small Arteriosclerosis, with  
myocardial degeneration and  
insufficiency of Central-  
Art. Circulation. (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY Cardiac failure —  
(Secondary) (duration) yrs. mos. / ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wesley Cole M. D.5/6, 1928 (Address) 2202 Garrison

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Fryersville Penna

DATE OF BURIAL

5/8 19 28

20 UNDER-PAKER

ADDRESS

Geo W Little

E 33633

## HEALTH DEPARTMENT - CITY OF BALTIMORE

E 33633

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: *City of Baltimore*

## 2-FULL NAME

(a) RESIDENCE NO. *505*

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *6* mos. *2* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day... hrs.  
or... min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15 Filed

AY 7 - 1928

HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

May 3, 1928, to May 6, 1928,  
that I last saw her alive on May 6, 1928,

and that death occurred, on the date stated above, at 11:25 A.M.

The CAUSE OF DEATH\* was as follows:

Ruptured appendix

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death? home

Did an operation precede death? yes Date of 3/3/28

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. A. Jones, M. D.

19 (Address) 555 North St.

\*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Woodlawn Cem.

20 UNDERTAKER

Wm. J. Pickens

May 10, 28  
ADDRESS  
North St.



E 33634

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74 E 33634

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2913 Huntingdon ST. WARD)

2-FULL NAME Annie Rebecca Morrison

(a) RESIDENCE No. 2913 Huntingdon ST. WARD  
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore H. Morrison

6 DATE OF BIRTH (month, day, and year) Nov 16 1860

7 AGE Years 67 Months 5 Day 17 If LESS than 1 day, hrs or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

PARENTS

14 Informant Mrs. J. B. Howell  
(Address) 2913 Huntingdon Ave

15 Filed 19 HAMMOND REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3-28

17 I HEREBY CERTIFY, That I attended deceased from April 3rd, 1928 to May 3rd, 1928, that I last saw her alive on May 13th, 1928, and that death occurred, on the date stated above, at 7:30 P. m. The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Atherosclerosis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? (duration) 2 yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination  
(Signed) George B. Cross, M. D.  
, 19 (Address) 280 W 25th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Woodlawn

DATE OF BURIAL

20 UNDERTAKER Chenoweth

May 7 1928  
ADDRESS

*Melvin Fuller*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33635

## CERTIFICATE OF DEATH.

E 33635

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hosp* ST. *12-51* WARD)

## 2-FULL NAME

*Fuller, Melvin*

## (a) RESIDENCE NO.

*507 W. 27<sup>th</sup>*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

*Life*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*male*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Child*

## 6 DATE OF BIRTH (month, day, and year)

*July 12, 1924*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*8 years 9 months 17 days*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*md*

## 10 NAME OF FATHER

*Fuller, Richard. ns*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*md*

## 12 MAIDEN NAME OF MOTHER

*Weaver, Marion*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*md*

## 14

Informant (Address)

*Richard Fuller 507 W. 27<sup>th</sup> St*

## 15

Filed

19

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*May 4, 1928*

## 17

I HEREBY CERTIFY, That I attended deceased from *5-1-28*, 19*28*, to *5-6-*, 19*28*.that I last saw him alive on *2-2-*, 19*28*.and that death occurred, on the date stated above, at *1:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Diffuse peritonitis (pneumococcal in origin)*

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

*Broncho-pneumonia*

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted

if not at place of death?

*unknown*

Did an operation precede death?

*yes*

Date of

*5-1-28*

Was there an autopsy?

*no**Biopsy of Bulbourethral Gland*

What test confirmed diagnosis?

(Signed)

*F. B. League*

M. D.

, 19

(Address)

*University Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

*Greenwood Burial Ground May 9, 1928*

## 20 UNDERTAKER

## ADDRESS

*Chenoweth Son & Co.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33636

E 33636

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *807 Powers*ST. *13-52* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Ellsworth Tracy*

(a) RESIDENCE NO.

(Usual place of abode)

*807 Powers*

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*

(a) If married, widowed, or divorced

HUSBAND

WIFE

*Katherine M. Tracy*

6 DATE OF BIRTH (month, day, and year)

*Sept 4/1894*

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

*33.**8**✓*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Conductor*

(b) General nature of industry, business, or establishment in which employed (or employer)

*R. & E. Co.*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balti city*

10 NAME OF FATHER

*Thomas Tracy*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balti*

12 MAIDEN NAME OF MOTHER

*Mary E. Price*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ind.*

14

Informant (Address)

*Katherine M. Tracy (wife)*  
*807 Powers St*

15

Filed

*7-182*  
*C. HAMMOND JONES, M. D.*  
*Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 6, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 10, 1928* to *May 6, 1928*that I last saw him alive on *May 6, 1928*and that death occurred, on the date stated above, at *10:15 P. m.*

The CAUSE OF DEATH\* was as follows:

*Encephalitis Lethargica*(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *Hubert C. Knapp* M. D.*May 6, 1928* *Hubert C. Knapp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Bedford Hill Cem. R. A. Co.**May 9, 1928*

20 UNDERTAKER

ADDRESS

*J. Walter Davis 3307 Paine St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33637

CERTIFICATE OF DEATH.

129 E 33637

1-PLACE OF DEATH

City of BALTIMORE: (No. 122 Ridgely St. between 125-73 St. Ward)

2-FULL NAME

Carrice Robinson

(a) RESIDENCE NO. 122 Ridgely St. between 125-73 St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

Colored

5 Single, Married, Widowed, or Divorced. (Write the word)

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Richard Robinson

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE

Years

58

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Va.

10 NAME OF FATHER

John Atkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Clayton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va.

14

Informant (Address)

Richard Robinson  
122 Ridgely St.

15

Filed

19

C. HAMMON JONES, M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/5/28

19 28

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 30, 1928, to May 5, 1928

that I last saw him alive on May 2, 1928

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic Bright's Disease

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?.....Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

5/5/28 1928 (Address) 122 Ridgely St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

122 Ridgely St. 4/8/28

20 UNDERTAKER

ADDRESS

Samuel P. Remick

very important. See instructions on back of

AY 7-1928



**E 33638 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33638**

**CERTIFICATE OF DEATH.**

**1. PLACE OF DEATH**

CITY OF BALTIMORE: (No. 510 Combal ST. 2230 WARD)

2. FULL NAME Louisa Cole

(a) RESIDENCE NO. 510 Combal ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Cole (deceased)

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years Months Days If LESS than 1 day, hrs or min. 45

8 OCCUPATION OF DECEASED at home work

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Clara Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant (Address) Joseph M. Moore 510 Combal Alley

15 Filed 1928 C. HARRISON JONES, JR. Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) May 3 1928

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1928 to May 4, 1928, that I last saw her alive on May 3, 1928 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis  
(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) J. H. McLean M. D.

5/5, 1928 (Address) 2005 Hillman

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Zion Ct

May 7 1928

20 UNDERTAKER

ADDRESS

J. W. Brown & Son 108 N. Montg

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33639

## CERTIFICATE OF DEATH.

E 33639

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2113 Dinslow* ST. *14-59* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *2113 Dinslow* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Female Colored Married*5a If married, widowed, or divorced  
HUSBAND of  
or WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

7-1928

C. HAMMON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
*Dec 15, 1928* to *May 5, 1928*,  
that I last saw him alive on *May 4, 1928*,  
and that death occurred, on the date stated above, at *1235 A. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*Wm. Auburn cemetery*  
*Thomas G. Kelom**4/9 1928*  
*Presman*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33640

## CERTIFICATE OF DEATH.

16-002

E 33640

REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1723 S. Clinton St. 26-36 Ward)

2-FULL NAME Mary K. Lackel

(a) RESIDENCE NO. 1723 S. Clinton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23<sup>rd</sup> / 1927

7 AGE Years 7 Months 12 Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Ind.

10 NAME OF FATHER Ludwig Lackel

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary Steger

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mary Lackel (Address) 1723 S. Clinton St.

15 Filed C. HANCOCK, JR. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5<sup>th</sup> 1928

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1928, to May 5, 1928, that I last saw her alive on May 4, 1928, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH\* was as follows:

Acute Dysentery Bacillary

CONTRIBUTORY (duration) yrs. mos. 5 ds. Acute Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Titlow, M. D. 5/5, 1928 (Address) 311 S. Highland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Sacred Heart Cem May 7 1928

20 UNDERTAKER

Lilly + Zeiler Inc. 403 S. Wolfe St

very important. See instructions on back of

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33641

## CERTIFICATE OF DEATH.

129 E 33641

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2810 Simpson St. 9-46 Ward)

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ada Sligh

(a) RESIDENCE NO. 2810 Simpson

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

12.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

F

COL

Married

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Irry Sligh

6 DATE OF BIRTH (month, day, and year)

Feb 17/1835

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

43

2

17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Union, S.C.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

B

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

B

14

Informant  
(Address)Irry Sligh  
2810 Simpson St.

15 Filed

19

HAMPSON JONES

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 4/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to her death (copy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chr. Nephritis- Chr. Myocarditis

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(duration) .....yrs. ....mos. ....ds.

(Coroner)

M. D.

5/9/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mt. Calvary Ant.

May 7, 1928

20 UNDERTAKER

Mrs. R. G. Elliott

ADDRESS

1725 Washington



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33642

CERTIFICATE OF DEATH

128 ✓

E 33642

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 813, Paragoy Ave.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Jane Quickley

(a) RESIDENCE NO. 813 Paragoy Ave.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S. if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX ♀ 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of ?

DATE OF BIRTH (month, day, and year) October 1878

AGE 50 Years 49 Months ? Days ? If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Co. Md. (State or country)

10 NAME OF FATHER Mose Quickley

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Rachel ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Mary Quickley (Address) 813 Paragoy Ave.

15 Filed MAY 7 - 1928 Registrar M. J. Jones

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4. 28

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1928, to May 4, 1928, that I last saw her alive on May 3, 1928 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH\* was as follows:

acute myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Ex.

(Signed) W. L. Berry, M. D.

, 19 (Address) 1420 E. Chase

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Long Green Md.

20 UNDERTAKER Wm. R. G. Effert

DATE OF BURIAL May 7, 1928

ADDRESS 1725 Washington

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33643

## CERTIFICATE OF DEATH.

74-00E 33643

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1518 N. Lenoire St. Ward 16-22)2-FULL NAME Riley Street(a) RESIDENCE NO. 1518 N. Lenoire St. Ward 16-22

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of Elinor Street (or) WIFE of6 DATE OF BIRTH (month, day, and year) Dec. 4<sup>th</sup> 18837 AGE 44 Years 45 Months 3 Days 4 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common labor(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co. Va.

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Elinor Street(Address) 1518 N. Lenoire St.15 Filed 1928 HARRISON JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/1928 1917 I HEREBY CERTIFY, That I attended deceased from May 3, 1928, to May 4, 1928that I last saw him alive on May 4, 1928and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH\* was as follows:

General Paralysis  
(duration) about 2 hours yrs. mos. ds.CONTRIBUTORY Cerebral Hemorrhage  
(Secondary) a few hours (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physician(Signed) John H. Thompson, M. D.Address 1012 N. Lenoire St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Date of Burial May 7, 192820 UNDERTAKER Mrs. R. H. Elliott ADDRESS 1725 Baltimore

very important. See instructions on back of card.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33644

## CERTIFICATE OF DEATH.

E 33644

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Qin 6- Pratt St. Ward 17)2-FULL NAME Robert S. Gibson(a) RESIDENCE NO. 2035-7, Washington St. 17 Ward 17

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 0 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 18 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 Color or Race White5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) century

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Motor maker(b) General nature of industry, business, or establishment in which employed (or employer) Ind. motor work(c) Name of employer 0869 BIRTHPLACE (city or town) Baltimore

(State or country)

10 NAME OF FATHER Paul R.11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Carl Lembrich13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14

Informant (Address) W. S. Gibson  
2035 Washington

15

Filed

19

HAMPSON JONES, M. D.

Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 192617 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute dentally Chronic  
Qin 6 Pratt St. Fall(duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 10 yrs. 0 mos. 0 ds.(Signed) W. S. Gibson M. D.19 26 (Address) 1639 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death Qin 6 Pratt St. yrs. 0 mos. 0 ds. In the State 17 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem Date of Burial 5/7 19-28

20 UNDERTAKER

Philip Herwig ADDRESS 2016

very important. See instructions on back of certificate.

## E 33645 HEALTH DEPARTMENT—CITY OF BALTIMORE

33645

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2316 E. Oliver* ST., *8-16* WARD)

## 2. FULL NAME

*Augusta Seiler*

## (a) RESIDENCE NO.

*2316 E. Oliver*

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

*46* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

*Female White*

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

*John Seiler*

DATE OF BIRTH (month, day, and year)

*May 30 1838*

## AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*89**11**10*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Germany*

## 10 NAME OF FATHER

*Seiler*

## PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Hypner*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

## 14

Informant (Address)

*Emil L. Seiler 2316 E. Oliver St.*

## 15

Filed

*May 7 1928**HAMPSHIRE JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 5 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 20*, 19*28*, to *May 5*, 19*28*that I last saw him alive on *April 27*, 19*28*and that death occurred, on the date stated above, at *2 30* m.

The CAUSE OF DEATH\* was as follows:

*arterio Sclerosis*  
*cannot say definitely*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Arterio Sclerosis*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*J. W. Jones*, M. D.Address *1801 E. Gay St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Baltimore Cem**5/8/28*

20 UNDERTAKER

ADDRESS

*Philip Hewig**Oceanside*



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33646

## CERTIFICATE OF DEATH

E 33646

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *627 South 14<sup>th</sup>* ST., *Highlandtown* WARD)

### 2. FULL NAME

*William Thomson*

### (a) RESIDENCE NO.

*627 South 14<sup>th</sup>*

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

ST.,

WARD

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

#### SEX

*Male*

#### 4 COLOR OR RACE

*W*

#### 5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

If married, widowed, or divorced HUSBAND of (or) WIFE of *Sarah Thomson*

#### 6 DATE OF BIRTH (month, day, and year)

*May 5 1861*

#### 7 AGE

*67* Years

Months

Days

If LESS than 1 day, hrs or min.

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

*Scotland*

#### 10 NAME OF FATHER

*Unknown*

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Unknown*

#### 12 MAIDEN NAME OF MOTHER

*Unknown*

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Unknown*

#### 14

Informant (Address)

*Mr. James Thomson 627 S 14<sup>th</sup>*

#### 15

Filed

*May 7 1928* *H. H. Jones, M. D.* Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

*May 5 1928*

#### 17

I HEREBY CERTIFY, That I attended deceased from *May 2<sup>nd</sup>*, 1928, to *May 5<sup>th</sup>*, 1928

that I last saw him alive on *May 4<sup>th</sup>*, 1928

and that death occurred, on the date stated above, at *3 A.* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage + Nephritis*

(duration) yrs. mos. *4* ds.

#### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Adam Tod*, M. D.  
, 19 (Address) *4700 Eastern Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Oak Lawn*

*May 7 1928*

#### 20 UNDERTAKER

*John F. Denny 715 Light St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33647

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

Registered No. C. 33647

City of BALTIMORE: (No. *City Hospital* St. *5-8* Ward)

2-FULL NAME

*Engine Collins*  
*1112 Colvin*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *10* St.; yrs. *10* mos. *10* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>M</i>	4-COLOR OR RACE <i>C</i>	5-Single, Married, Widowed, or Divorced. (Write the word.) <i>W</i>
6-DATE OF BIRTH <i>Sept</i> (Month) <i>1</i> (Day) <i>1928</i> (Year)		
7-AGE <i>45</i> yrs. <i>10</i> mos. <i>10</i> ds.		If LESS than 1 day, <i>4</i> hrs. or <i>10</i> min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Laborer</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>40</i>		
9-BIRTHPLACE, (State or Country). <i>Ind</i>		
PARENTS	10-NAME OF FATHER.	
	11-BIRTHPLACE OF FATHER, (State or Country). <i>Ind</i>	
	12-MAIDEN NAME OF MOTHER.	
	13-BIRTHPLACE OF MOTHER, (State or Country). <i>Ind</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John H. Atkins*  
(Address) *134 Colvin St*

15-

Filed 7-1928

C. HAMMOND JONES, M. D.  
*Reg.*

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *May* *21*, 19*28*  
(Month) (Day) (Year)17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)*Inquiry* thereon and from the evidence obtained by said *Inquiry* find that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

CONTRIBUTORY (Secondary)

*Exhaustion* (Duration) *2* mos. *2* ds.*May 9* (Date) *143 W 3rd* (Address) *Ind* (City)  
*2/28* 19*28* (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death. *10* yrs. *10* mos. *10* ds. In the State. *10* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Ashbury Cem**5/27* 19*28*

20-UNDERTAKER.

ADDRESS

*Byron Knight 1218 E. Elderry St*

33648

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

21 E 33648

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL*)

2-FULL NAME *ANNIE L. DITTUS*

ST. *8-16* WARD

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. *1730 R. Collington Ave*

(Usual place of abode)  
Length of residence in city or town where death occurred

ST. WARD

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 20<sup>th</sup> 1874*

7 AGE Years Months Days *53 11 14* If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Shop Keeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ind*

10 NAME OF FATHER *Brechevits*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Saphie Wiskelma*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ind*

14 Informant *Records* (Address) *JOHNS HOPKINS HOSPITAL*

15 Filed *7-1928* C. HANSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 5 1928*

17 I HEREBY CERTIFY, That I attended deceased from *April 25*, 19*28*, to *May 5*, 19*28*, that I last saw her alive on *May 5*, 19*28*, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:  
*Exsufflas. Bronchopneumonia*

CONTRIBUTORY (Secondary) *Bronchopneumonia* (duration) yrs. mos. *15* ds.

18 Where was disease contracted if not at place of death? *Baltimore*

Did an operation precede death? *No* Date of

Was there an autopsy? *No* What test confirmed diagnosis? *Exsufflas. Bronchopneumonia. Blood Culture* (Signed) *F. J. Goman*, M. D.

19 (Address) *Johns Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Loudon Park Cemetery* DATE OF BURIAL *5/7/1928*

UNDERTAKER *E. J. Fanning & Son - 1938 E. Lafayette St.*

33649

# HEALTH DEPARTMENT—CITY OF BALTIMORE

33649

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL*)

ST. *1-3* WARD)

REGISTERED NO. *90*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

*Helma Neilbert*

### (a) RESIDENCE NO.

*2323 Eastern Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. mos.

ST. *1-3* WARD

(If non-resident give city or town and State)  
How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

*Female*

#### 4 COLOR OR RACE

*White*

#### 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

*for 4/19/12*

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*15 yrs*

*6*

*2*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 9 BIRTHPLACE (city or town) (State or country)

*Md.*

### 10 NAME OF FATHER

*Louis Neilbert*

### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

### 12 MAIDEN NAME OF MOTHER

*Estherine Trice*

### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

### 14

Informant

(Address) *Records* *JOHNS HOPKINS HOSPITAL*

### 15

Filed

*7-1928* *HAMPSON JONES, M. D.* Registrar

Per *REB*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 6* 19 *28*

17 I HEREBY CERTIFY, That I attended deceased from *March 23*, 19 *28*, to *May 6*, 19 *28*, that I last saw her alive on *May 6*, 19 *28*, and that death occurred, on the date stated above, at *9:25 P. M.*

The CAUSE OF DEATH\* was as follows:

*Rheumatic Heart Disease*

(duration) *6* yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *at home*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*Lynnan Mules*

M.D.

*5-6-1928* (Address)

*Johns Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Oak Lawn Cemetery*

### DATE OF BURIAL

*May 9 1928*

### 20 UNDERTAKER

*Robert J. Turner Inc* 1442 N. Broadway



33650

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33650

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Beth City Hospital 10-37 WARD)

2-FULL NAME Mary Prus

(a) RESIDENCE No. 3809 Fernwood  
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ST. \_\_\_\_\_ WARD \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) 6-4-92

AGE 35 (Years) Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Adam Rosenwald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Katie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Heard and J. Prus  
(Address) 3808 Fernwood

15 Filed 7-1-28 19 HAMMON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-1928

17 I HEREBY CERTIFY, That I attended deceased from 5-2-1928 to 5-4-1928 that I last saw him alive on 5-4-1928 and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia Left

CONTRIBUTORY (Secondary) Unknown (duration) \_\_\_\_\_ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home (duration) \_\_\_\_\_ yrs. mos. ds.

Did an operation precede death? no Date of 5-2-28

Was there an autopsy? no

What test confirmed diagnosis? Cytopsy & internal  
(Signed) Callaghan, M.D.

, 19 (Address) Beth City Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Stanislaus

20 UNDERTAKER Alphonse J. Falkowski

DATE OF BURIAL May 8 1928

ADDRESS 3808 Fernwood



33652

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57 E 33652

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hosp. ST.* 18-16)2. FULL NAME *Mrs Anna Kennard.*(a) RESIDENCE NO. *835 W. Fayette St.* ST.,(Usual place of abode)  
Length of residence in city or town where death occurred *32* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female. White.**Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*John H. Kennard*

6 DATE OF BIRTH (month, day, and year)

*1865. 17th*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*62**8**18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland.*

10 NAME OF FATHER

*Eugene Kennard*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Massachusetts*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Massachusetts*

14 Informant (Address)

*Stewart R. Kennard**2113 Brookfield Ave*

15

Filed

7-1928

C. HANCOCK JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-5-28* 1917 I HEREBY CERTIFY, That I attended deceased from *11-28-27*, 19, to *5-5-28*, 19that I last saw her alive on *5-5-28*, 19, and that death occurred, on the date stated above, at *10 30* p. m.

The CAUSE OF DEATH\* was as follows:

*Post operative Diabetic gangrene of stump of left leg & infection*

CONTRIBUTORY (Secondary)

(duration) yrs. *1* mos. ds.(duration) yrs. *1* mos. ds.18 Where was disease contracted if not at place of death? *Home.*Did an operation precede death? *yes.* Date of *12-12-27*Was there an autopsy? *No* *4-4-28.*What test confirmed diagnosis? *Clinical*

(Signed)

*Frederic M. Stace*, 19 (Address) *Franklin Square Hospital* M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Laurel Park*

DATE OF BURIAL

*5/8-1928*

20 UNDERTAKER

ADDRESS

*H. B. Brown & Son, 1136 Poplar Grove St*

# E 33653 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *18-29* WARD)

2-FULL NAME *Tenneth B. Heacock*

(a) RESIDENCE NO. *1202 W. Lombard St* ST.  WARD   
(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

REGISTERED NO. *100-001* E 33653

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *July 2, 1927*  
AGE Years *0* Months *10* Days *3* If LESS than 1 day, hrs. or min.

### 6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)

10 NAME OF FATHER *Chas. Heacock*

11 BIRTHPLACE OF FATHER (city or town) *Balto, Co.* (State or country)

12 MAIDEN NAME OF MOTHER *Maudie Bramble*

13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country)

14 Informant *Mrs. Chas. Heacock* (Address) *1202 W. Lombard St*

15 Filed *1928* Registrar *R. L. H.*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 5 1928*

17 I HEREBY CERTIFY, That I attended deceased from *May 2*, 1928, to *May 5*, 1928, that I last saw him alive on *May 5*, 1928, and that death occurred, on the date stated above, at *5:40 P. M.* The CAUSE OF DEATH\* was as follows:

*Bilateral Bronchopneumonia*

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *9*

18 Where was disease contracted *Home* if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical* (Signed) *Neuron G. Tull*, M. D. (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Landon Park* DATE OF BURIAL *May 8<sup>th</sup> 1928*

20 UNDERTAKER *Thos. Tull* ADDRESS *1200 W. Lombard*



# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

13632  
E 33654

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

20-37  
ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frederick Jung Hunt

(a) RESIDENCE NO.

3901 E - Pratt ST.

WARD

(Usual place of abode)  
Length of residence in city or town where death occurred

42 yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Margaret Jung Hunt

7 DATE OF BIRTH (month, day, and year)

Sept. 16, 1867

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

60

18

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER

Henry Ger -

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

Catherine Bennett

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ger -

14

Informant  
(Address)

Records -

15

Filed

L. A. HARRISON JONES, M. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 30, 1928, to May 7, 1928.

that I last saw him alive on May 7, 1928,

and that death occurred, on the date stated above, at 7:29 - m.

The CAUSE OF DEATH\* was as follows:

Carbosis of the Liver  
Secondary anaemia

(duration) 1 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) James Bordeny, M. D.

5-7, 1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MORAL Oak Lawn Cemetery

DATE OF BURIAL

May 9 1928

20 UNDERTAKER

John Uelrick

ADDRESS

2018 Orleans St

E 33655

# HEALTH DEPARTMENT—CITY OF BALTIMORE

33655

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 W. Fairmount Ave. ST. 20-27 WARD)

2-FULL NAME Bridget Connelly,

(a) RESIDENCE NO. 1817 W. Fairmount Ave. ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)  
yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced  
HUSBAND of Late Michael Connelly  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11, 1869

7 AGE 58 Years 5 Months 24 Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER Thomas Conelius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gormley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James J. Connelly (Address) 1817 W. Fairmount Ave.

15 Filed 1928 HAZEL JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1928

17 I HEREBY CERTIFY, That I attended deceased from Jan 1928 to May 5 1928, that I last saw him alive on May 5 1928 and that death occurred, on the date stated above, at 6:30 p. m. The CAUSE OF DEATH\* was as follows: Catarrh of the stomach - 24.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Acute gastritis

18 Where was disease contracted if not at place of death? yrs. mos. ds. 1

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) Edward Revolutum, M. D. 77, 1928 (Address) 24 H. Fuller St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

New Cathedral Cemetery May 8 1928 John J. Cowan & Co. 401 N. Holliday St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33657

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 420 Francett St. 17-51 Ward)2-FULL NAME Donald Johnson(a) RESIDENCE NO. 420 Francett

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

Filed

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JOHNS HOPKINS HOSPITAL MAY 5 - 1926

20 UNDERTAKER

Registrar

ADDRESS

E 33657

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3 192817 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquest  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said inquest  
(Inquest, au-  
topsy or inquiry.) and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH was as follows:

PneumoniaCONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner)

M. D.

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place

of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

JOHNS HOPKINS HOSPITAL

MAY 5 - 1926

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2620 Boone St. ST. 7-46 WARD)

2. FULL NAME Baby Johnson

(a) RESIDENCE NO. 2620 Boone St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male AA Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, 1/2 hrs. or 50 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 20

(b) General nature of industry, business, or establishment in which employed (or employer) 20

(c) Name of employer 100

9 BIRTHPLACE (city or town) 2620 Boone St. (State or country) Baltimore Md

10 NAME OF FATHER Morris Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Morris Johnson (Father) (Address) 2620 Boone St

15 Filed 1928 19 HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1928

17 I HEREBY CERTIFY, That I attended deceased from May 4 1928, to May 4 1928, that I last saw him alive on May 4 1928, and that death occurred, on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH\* was as follows: Physical condition of mother and premature Birth

CONTRIBUTORY (duration) yrs. mos. ds. Physical condition of mother (duration) 7 yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. H. Hall, M. D.

19 (Address) 426 E. 23rd St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

HOPKINS HOSPITAL MAY 5 - 1928

20 UNDERTAKER ADDRESS

Schlesinger &amp; Son



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33660

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 W. Lanvale. ST. 16-28 WARD)

2—FULL NAME

Harry Lee Meiser

(a) RESIDENCE NO.

2005 W. Lanvale. ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

July 7-1919

AGE

Years

Months

Days

8

9

28

If LESS than  
1 day, hrs.  
or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Balt

10 NAME OF FATHER

Herman M Meiser

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balt

12 MAIDEN NAME OF MOTHER

Helen J. Hustar

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Balt

Informant

Herman M. Meiser

(Address)

2005 W. Lanvale

Filed

1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 5-1928

17

I HEREBY CERTIFY That I attended deceased from  
April 6-1928, to May 5-1928,  
that I last saw him alive on May 2-1928

and that death occurred, on the date stated above, at 11:10 a. m.

The CAUSE OF DEATH\* was as follows:

Dilatation of Heart

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 5 ds.

Bronchial Pneumonia

(duration) yrs. mos. 23 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? - Physical Signs & Symptoms  
(Signed) Chester Riland, M. D.

5-5-1928 (Address) 2532 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MORTAL

DATE OF BURIAL

Western Cemetery

May 8 1928

20 UNDERTAKER

Wm Book

ADDRESS

502 E North Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

33661

49 E 33661

### 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 E 29th ST., 9-46 WARD)

2—FULL NAME John E. Carpenter

(a) RESIDENCE NO. 1606 E 29th ST.,

Length of residence in city or town where death occurred 20 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)  
How long in U. S., if foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Carpenter

DATE OF BIRTH (month, day, and year) May 11, 1857

AGE Years 70 Months 11 Days 23 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Steam Boat

(c) Name of employer U. S. Government

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER George W. Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eleanor Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mary E. Carpenter

(Address) 1606 E 29th St

Filed 19 HAMPSON JONES, M. R. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1928

17 I HEREBY CERTIFY That I attended deceased from Aug 1, 1927, to May 5, 1928, that I last saw him alive on May 5, 1928, and that death occurred, on the date stated above, at 10:20 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds. Chronic Prostate infection in bladder (Secondary)

Myocardial Chorea (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen B. Leman, M. D. 5/5, 1928 (Address) 7189 Ballou Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- BURNED DATE OF BURIAL

20 UNDERTAKER Address

7189 Ballou Place



E 33662

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33662

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St Agnes Hospital*

CITY OF BALTIMORE: (No.

2-FULL NAME *Edward C. Storch*

(a) RESIDENCE No. *2918 Reuse St*  
(Usual place of abode)

Length of residence in city or town where death occurred *1 yr.* yrs. mos. ds.

ST. *9-46* WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of *Ella Storch*

7 DATE OF BIRTH (month, day, and year) *Aug. 16, 1890*

7 AGE Years Months Days If LESS than 1 day, hrs or min  
*37* *8* *20*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Foreman*

(b) General nature of industry, business, or establishment in which employed (or employer) *Spice Dept*

(c) Name of employer *McCormick & Co*

9 BIRTHPLACE (city or town) (State or country) *Baltimore*

10 NAME OF FATHER *August Storch*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Augusta Peiper*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant *Mrs. Ella Storch*  
(Address) *2918 Reuse St*

15 Filed *7-1928* C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-6-* 19 *28*

17 I HEREBY CERTIFY, That I attended deceased from *5-3*, 19 *28*, to *5-6*, 19 *28*, that I last saw him alive on *5-6*, 19 *28* and that death occurred, on the date stated above, at *9:20 a. m.*  
The CAUSE OF DEATH\* was as follows:

*Acute Appendicitis*

CONTRIBUTORY (Secondary) *General Peritonitis* (duration) yrs. mos. ds. *3*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *5/4/28*

Was there an autopsy?

What test confirmed diagnosis? *Operation*  
(Signed) *Francis L. Badagliacca*, M. D.  
, 19 (Address) *St Agnes Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

*London Park*  
UNDERTAKER *Wm Cook*

*May 9* 19 *28*  
ADDRESS *507 E. North*

E 33663

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33663

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 17 WARD)REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Suggs(a) RESIDENCE NO. 2310 Greenmount Ave

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of William A. LeggDATE OF BIRTH (month, day, and year) 7/1/1868

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

60

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spalding, Md.10 NAME OF FATHER Charles Minnick11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania12 MAIDEN NAME OF MOTHER Edna13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant (Address) Records

15

Filed

19

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6/1928

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1926 to May 6, 1928that I last saw her alive on May 6, 1928and that death occurred, on the date stated above, at 7:40 P. M.

The CAUSE OF DEATH\* was as follows:

Hemiplegia - right - cerebral hemorrhage - arteriosclerosis - Hypertension(duration) 2 yrs. mos. ds.CONTRIBUTORY (Secondary) myocarditis, chronic(duration) 7 yrs. mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? General + Sale(Signed) C. Hampton Jones, M. D., 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

Greenmount May 9, 1928

20 UNDERTAKER

ADDRESS

W. H. Cook 500 E. North Ave

E 33664

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 E 33664

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST *27-44* WARD)2. FULL NAME *Mrs. Mary Mengert*(a) RESIDENCE NO. *4512 Weitzel Ave.*  
(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs. mos. ds.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced, (write the word) *Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *John G. Mengert*DATE OF BIRTH (month, day, and year) *Oct 11, 1865*

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min*62**6**26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) *Baltimore Md*10 NAME OF FATHER *John Schmus*11 BIRTHPLACE OF FATHER (city or town, State or country) *Germany*12 MAIDEN NAME OF MOTHER *M. Schmus*13 BIRTHPLACE OF MOTHER (city or town, State or country) *Holland*

14

Informant (Address) *John G. Mengert*  
*4512 Weitzel Ave*

15

Filed

19

C. HAMMOND JONES, M.D. Registrar

7-1828

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/7/28* 19

17

I HEREBY CERTIFY, That I attended deceased from *4/2/28*, 19 to *5/7/28*, 19 that I last saw her alive on *5/7/28*, 19 and that death occurred, on the date stated above, at *7 A.* m.

The CAUSE OF DEATH\* was as follows:

*hyperpnea*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary) *cardiac dilatation*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *4/30/28*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Lawrence Fanning* M.D.

19

(Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Johnwood*

DATE OF BURIAL

20 UNDERTAKER *W. W. Cook*

ADDRESS

*May 10 1928*  
*302 E. North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33665

## CERTIFICATE OF DEATH.

129 E 33665

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 Mura

ST. 10-14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Semone

(a) RESIDENCE NO. 730 Mura

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jm E Semone

6 DATE OF BIRTH (month, day, and year)

Nov 24<sup>th</sup> / 73

7 AGE

54 Years

Months 4

Days 12

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

George Link

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Ann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Jm E Semone 730 Mura

15

Filed

1928

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/6

1928

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1928, to May 6, 1928, that I last saw him alive on May 6, 1928, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Bright's disease

Unknown

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Semone, M. D.

7, 1928 (Address) 914 E Broad St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Burial London Park Cem

DATE OF BURIAL

5/9 1928

20 UNDERTAKER

Robert Brooks &amp; Son

ADDRESS

Calhoun Hollins



E 33666

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33666

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1900 Block Bank St)

## 2-FULL NAME

John Marzec

St. 2-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 312 332 S CastleSt. 2-4 WardLength of residence in city or town where death occurred 45 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

1858

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Retired

9 BIRTHPLACE (city or town)  
(State or country)

Poland

## 10 NAME OF FATHER

George Marzec

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Poland

## 14

Informant  
(Address)

Peter Marzec

2618

Orlean

St.

## 15 Filed

1928

C. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Stenosis

## CONTRIBUTORY (Secondary)

May 28

(Signed)

(Address)

(duration)

(Coroner)

(duration)

(Coroner)

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

## 20 UNDERTAKER

St Stanislaus May 8 1928  
John M. Weber 401 S Chester

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33667

## CERTIFICATE OF DEATH.

E 33667

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 26-27 Ward)2-FULL NAME Anna Blama(a) RESIDENCE NO. 520 S. 12th St St.          Ward         

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 1 mos.          ds.         

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 Color or Race

W

5 Single, Married, Widowed,  
or Divorced, (write the word)  
Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofMichael Blama

6 DATE OF BIRTH (month, day, and year)

Dec 24/1890

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.30412

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....none(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town).....

(State or country)

Poland

10 NAME OF FATHER

Andrew Kobal

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Katie Kobal

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

Poland

14

Informant  
(Address)Husband

15

Filed

C. HAMPTON JONES, M. D.  
Regist.REGISTERED NO.         (If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 6/20

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy, or inquiry.)thereon and from the evidence obtained by said inquiry  
(Inquest, au-topsy or inquiry.) and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Miliary Tuberculosis Liver, Spleen  
& Lungs. (Autopsy at Hopkins)

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(duration) ..... yrs. .... mos. .... ds.

(Signed) [Signature] M. D.

(Coroner)

5/1/20

(Address)

508 E. North Ave\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Rosary May 9 1920  
20 UNDERTAKER ADDRESS  
John M. Weber 401 S. Chester

Very Important. See instructions on back.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X *Life* 33668

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL*)

## 2-FULL NAME

*Sam Schultz*

## (a) RESIDENCE NO.

*Sommes Co -*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1* mos. *5* ds.

ST.,

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

*Pense - W - 2a -*

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White**Single*

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*Nov-1879*

AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

*49**6*

## 7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Sam Schultz*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*W - 2a -*

## 10 NAME OF FATHER

*Henry Schultz*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*W - 2a -*

## 12 MAIDEN NAME OF MOTHER

*Eli Smith*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*W - 2a -*

14

Informant

(Address)

*Records -*

15

Filed

19

*HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*March 28*, 1928, to*May 6*, 1928,

that I last saw him alive on

*May 6*, 1928,

and that death occurred, on the date stated above, at

*2 P. m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach with metastases to liver**Two years* (duration)

yrs.

mos.

ds.

## CONTRIBUTORY

(Secondary)

*Pneumonia* (duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*West Virginia*

Did an operation precede death?

*Yes*

Date of

*April 6, 1928*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*X-Ray & Laparotomy*

(Signed)

*J. S. Hart*

M. D.

19 (Address)

*Johns Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*Pence Springs W Va**5/7/28*

## 20 UNDERTAKER

## ADDRESS

*Josyph Ahrens**221 Bway*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33669

## CERTIFICATE OF DEATH.

90 E 33669

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2033 E. Hoffman St., 8-17 Ward)2-FULL NAME Bunyan S. Hammonds(a) RESIDENCE NO. 2033 E. Hoffman St. 8-17 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena P. Hammonds6 DATE OF BIRTH (month, day, and year) Aug 4/1859

7 AGE Years 68 Months 9 Days 2 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter(b) General nature of industry, business, or establishment in which employed (or employer) 50

(c) Name of employer

9 BIRTHPLACE (city or town) Irvington, Va.  
(State or country)10 NAME OF FATHER George Hammonds11 BIRTHPLACE OF FATHER (city or town) Va.  
(State or country)12 MAIDEN NAME OF MOTHER Lucy B. Barrett13 BIRTHPLACE OF MOTHER (city or town) Va.  
(State or country)14 Informant George P. Hammonds  
(Address) 2033 E. Hoffman St.15 1928 C. HAMMONS JONES, M.D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cardiac Valvular Insufficiency(duration) 3 P.m. yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) J. H. Jones M. D.

(Coroner)

(Address)

5/6/28 503 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Baltimore Cemetery May 9 1928

20 UNDERTAKER

Mrs C. Miller & Son 2334 Jefferson St



# HEALTH DEPARTMENT— OF BALTIMORE

E 33670

## CERTIFICATE OF DEATH.

31 E 33670

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 N. Payson, St.

ST. 15-21 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Tabitha Ashburn.

(a) RESIDENCE No. 1509 N. Payson, St.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 5 yrs. mos. ds.

How long in U. S., If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female. White.

Widow.

5a If married, widowed, or divorced

WIFE of the late James W. Ashburn.

6 DATE OF BIRTH (month, day, and year) April 27/1860.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

63.

0.

9.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

at home.

(c) Name of employer

retired.

9 BIRTHPLACE (city or town) Gloucester, Co. Virginia.

10 NAME OF FATHER John E. Turlington.

11 BIRTHPLACE OF FATHER (city or town) Maryland.

12 MAIDEN NAME OF MOTHER Rosa J. Oliver.

13 BIRTHPLACE OF MOTHER (city or town) Virginia.

14 Informant Andrew F. Ashburn. (Address) 1509 N. Payson, St.

15 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 6th. 19 28.

17

I HEREBY CERTIFY, That I attended deceased from 1927 to May 6, 1928, that I last saw her alive on May 6, 1928, and that death occurred, on the date stated above, at 9-15. AM.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs (Signed) J. H. Davis, M. D.

577, 1928 (Address) Medical Arts Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Irvington. Va.

DATE OF BURIAL

May, 3/ 19 28.

20 UNDERTAKER

J. Walter Davis, 3307. Paine St.

E 33671

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33671

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

BALTIMORE CITY HOSPITAL

ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Ann

## (a) RESIDENCE NO.

1319 Ashland Ave.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

?

DATE OF BIRTH (month, day, and year)

?

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Alice

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Mary Ann Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

Records

15

Filed

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/1928

17

I HEREBY CERTIFY, That I attended deceased from

May 3, 1928 to May 4, 1928

that I last saw her alive on May 4, 1928

and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis chronic &amp; acute

Initial myocarditis

Cholera - pneumonia

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General &amp; Sub

(Signed) C. Holmes Jones, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Ashbury Cemetery

May 9, 1928

20 UNDERTAKER

ADDRESS

Wendell J. Whipple

3008 Colver

33672

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33672

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 E. Hing ST. 14-59 WARD)

### 2-FULL NAME

George W. Stewart Jr

(a) RESIDENCE NO. 2118 E. Hing ST., 14-59 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. 0 mos. 0 ds.

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Sept 8, 1923

7 AGE Years 5 Months 7 Days 27 If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Baltimore (State or country) md.

10 NAME OF FATHER George W. Stewart

11 BIRTHPLACE OF FATHER (city or town) md. (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Bessie Waters

13 BIRTHPLACE OF MOTHER (city or town) md. (State or country) \_\_\_\_\_

14 Informant George W. Stewart (Address) 2118 E. Hing St

15 Filed 1928 C. HANCOCK JONES, M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5 19 28

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1928, to May 5, 1928, that I last saw him alive on May 5, 1928 and that death occurred, on the date stated above, at 7:10 m. The CAUSE OF DEATH\* was as follows:

Tuberculous Meningitis  
(duration) yrs. 0 mos. 30 ds.

CONTRIBUTORY (Secondary) Measles  
(duration) yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? \_\_\_\_\_

(Signed) J. M. Card M. D. 17, 1928 (Address) 2005 Druid Hill Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL mt Zion Cemetery DATE OF BURIAL May 8, 1928

20 UNDERTAKER Thomas G. Nelson ADDRESS 303

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33673

## CERTIFICATE OF DEATH

E 33673

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Provident Hospital* St. *16-22* Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Ann Beads*(a) RESIDENCE NO. *1203 Whatecoat* St. *16-22* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. *0* mos. *0* ds.How long in U. S. if of foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Arthur Beads*

6 DATE OF BIRTH (month, day, and year)

*Aug. 21, 1891*

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

*36 8 15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Domestic at 027 home.*

9 BIRTHPLACE (city or town)

(State or country)

*Essex Co. Va*10 NAME OF FATHER *John Jones*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Essex Co. Va*12 MAIDEN NAME OF MOTHER *Mary Lewis*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Essex Co. Va.*

14

Informant (Address)

*Arthur Beads, 1203 Whatecoat St.*

15

1928

*C. HAMPSON JONES, M.D., Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-6-1928*

17

I HEREBY CERTIFY, That I attended deceased from

*4-26, 1928, to 5-6, 1928,*that I last saw her alive on *5-6, 1928,*and that death occurred, on the date stated above, at *1:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Appendicitis & rupture of mesenteric artery*(duration) *1* yrs. *0* mos. *0* ds.

CONTRIBUTORY

(Secondary)

(duration) *1* yrs. *0* mos. *0* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *yes* Date of *5/3/28*Was there an autopsy? *no*What test confirmed diagnosis? *operation*

(Signed)

*C. H. Beck M.D.*

(Address)

*600 Washington Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Arthur Beads**May 9 1928*

20 UNDERTAKER

ADDRESS

*Thomas G. Nelson**1303 Madison St.*



# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33674

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 N. Chester ST. 8-17 WARD)

2—FULL NAME *Bertha Roszkopf Hammerschlag*

(a) RESIDENCE NO. 1918 N. Chester ST. WARD

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if foreign birth 40 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *Female white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

If married, widowed, or divorced, HUSBAND or (or) WIFE of *Joseph Hammerschlag*

DATE OF BIRTH (month, day, and year) *June 6 1869*

AGE Years 60 Months 11 Days 1 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Germany*

10 NAME OF FATHER *Nathaniel Appel*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *M. Kuhn*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

Informant *Jack Lewis*

(Address) *1439 E. Baltimore*

Filed 1928 19 *ALAN JONES, M. Registrar*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 7, 1928*

17 I HEREBY CERTIFY, That I attended deceased from *April 22, 1928* to *May 7, 1928*

that I last saw her alive on *May 6, 1928*

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *15* ds.

CONTRIBUTORY *Hypostatic Congestion of Lungs*

(Secondary) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *2* ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *no*

What test confirmed diagnosis? *None*

(Signed) *Hubert C. Knappe*, M. D.

*May 7, 1928* (Address) *1216 E. Pringle St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Baltimore Kehren Co.* DATE OF BURIAL *5/9 1928*

20 UNDERTAKER *Jack Lewis 1439 E. Baltimore* ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33675

## CERTIFICATE OF DEATH.

44 E 33675

## 1-PLACE OF DEATH

CITY OF BALTIMORE:

(No. 2331 Barclay St

ST. 12-50

WARD)

## 2-FULL NAME

Abraham Fishman

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

2331 Barclay St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

22 yrs.

ms.

ds.

How long in U. S., if of foreign birth?

22 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Yetta Fishman

## 6 DATE OF BIRTH (month, day, and year)

1864

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

64

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Russia

## 10 NAME OF FATHER

Joseph Fishman

## PARENTS

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

## 14

Informant  
(Address)Morris Oppel  
2331 Barclay St

## 15

Filed

19

HAMILTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 7 - 19 28

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar. 12, 19 28, to May 7, 19 28.

that I last saw him alive on May 6, 19 28.

and that death occurred, on the date stated above, at 1:22 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Stomach  
intestines, liver.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. 9 mos. ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death? Yes Date of ?

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) George E. Shannon, M. D.

19 (Address) 700 N. Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Hehren Int. Carmel

5/8/28

## 20 UNDERTAKER

## ADDRESS

Jack Lewis 1439 5th St

MAY 8 - 1928

E0 33676

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33676

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)

## 2. FULL NAME

Simon Gordon

## (a) RESIDENCE NO.

2779 W. North Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

38 yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.,

WARD

ST.,

WARD

(If non-resident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of

Annie Gordon

DATE OF BIRTH (month, day, and year)

April 18, 1878

## AGE

Years

Months

Days

If LESS than 1 day, his or min.

5819

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

father

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Russia

## 10 NAME OF FATHER

Simon Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Rachel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 7, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1928, to May 7, 1928.that I last saw him alive on May 7, 1928.and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH\* was as follows:

Benign Prostatic Hypertrophy.

## CONTRIBUTORY (Secondary)

(duration) 3 yrs. 7 mos. 7 ds.Secondary Hemorrhage(duration) 7 yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

YesDate of Apr. 23, 1928

Was there an autopsy?

No

What test confirmed diagnosis?

Cystoscopic, etc.

(Signed)

5/7, 1928

(Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Heavenly Haven Run5/8, 1928

## 20 UNDERTAKER

## ADDRESS

Jack Lewis 1439 E. Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33677

## CERTIFICATE OF DEATH

31 E 33677

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1309 Argyle Ave Ward 5)2-FULL NAME George Lawson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1309 Argyle Ave St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race C 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beatrice Lawson6 DATE OF BIRTH (month, day, and year) June 8, 18917 AGE 36 Years 11 Months 0 Days 7 IF LESS than 1 day 0 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harmony - Halifax Co. Va  
(State or country)10 NAME OF FATHER John Lawson11 BIRTHPLACE OF FATHER (City or town) Va  
(State or country)12 MAIDEN NAME OF MOTHER Beatrice Wade13 BIRTHPLACE OF MOTHER (city or town) Va  
(State or country)14 Informant (Sister) Melvin S. Hester  
(Address) 1309 Argyle Ave15 Filed 1928 C. H. HAYDEN JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1928 1917 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1928, to May 5, 1928, that I last saw him alive on May 5, 1928, and that death occurred, on the date stated above, at 8:50 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary TuberculosisCONTRIBUTORY Exhaustion  
(Secondary)(duration) 5 yrs. 0 mos. 0 da.18 Where was disease contracted ?If not at place of death? ?Did an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

(Signed) H. P. Hughes M. D.5/5 1928 (Address) 825 N. Fremont Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elton, VaDate of Burial May 8, 192820 UNDERTAKER Mrs. Kate R. WilliamsADDRESS 322St. Schwab



E 33678

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33678

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

University Hospital 16-42 ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

William Francis Doyle

(a) RESIDENCE NO.

4407 Forrest View ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

1924

AGE

Years

Months

Days

About 3 6.

If LESS than  
1 day. hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md

10 NAME OF FATHER

Andrew H. Doyle

PARENTS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)

Hospital record

15

Filed

1928

HARRISON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/7/28 19

17

I HEREBY CERTIFY, That I attended deceased from

5/1/28, 19, to 5/7/28, 19,

that I last saw him alive on 5/7/28, 19,

and that death occurred, on the date stated above, at 7:56 P. m.

The CAUSE OF DEATH\* was as follows:

Typhoid

(duration)

yrs.

mos.

16 ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. J. Rusby

M. D.

, 19

(Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

M. Fahay &amp; Sons

ADDRESS

1827 W. North Ave.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33679

E 33679

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Corman ST. 15-22 WARD)

2-FULL NAME Alma Green

(a) RESIDENCE No. 1717 Corman ST. 15-22 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 1 yrs. 11 mos. 19 ds.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-16-26

7 AGE Years 1 Months 11 Days 19 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.

10 NAME OF FATHER Wesie Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER Gertrude Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant Gertrude Green (mother) (Address) 1717 Corman St

15 Filed C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1928

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1928, to May 5, 1928, that I last saw her alive on May 5, 1928, and that death occurred, on the date stated above, at 5.30 P. in. The CAUSE OF DEATH\* was as follows:

Peritonitis

CONTRIBUTORY (Secondary)

Constipation + Convulsions

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. M. E. Lumsden M. D.

(Address) 5-6 1928 708 E. 5th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Auburn Cemetery

20 UNDERTAKER

Mrs. M. J. Jones

DATE OF BURIAL

May 8 1928

ADDRESS

1234 E. 5th St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

33680

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

JOHNS HOPKINS HOSPITAL

ST.,

WARD)

### 2-FULL NAME

James Eugene Fowler

### (a) RESIDENCE NO.

(Usual place of abode)

Reisterstown Road

ST.,

WARD

Gwynn Road Ave.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

2

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

Baby

a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

DATE OF BIRTH (month, day, and year)

April 9 1928

AGE

Years

Months

Days

If LESS than

1 day... hrs

or... min.

yrs.

28 days

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md -

10 NAME OF FATHER

Thomas Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Carroll co Md

12 MAIDEN NAME OF MOTHER

Anna McGinnis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14 Informant (Address)

Records - JOHNS HOPKINS HOSPITAL

15 Filed

G. HAMMOND JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 7 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1928, to May 7, 1928,

that I last saw him alive on May 7, 1928,

and that death occurred, on the date stated above, at 3:20 a-m.

The CAUSE OF DEATH\* was as follows:

Meningitis (acute) Streptococcus

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Birth injury

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

At Home

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Cultures from spinal fluid

(Signed)

B. C. Goodwin

M. D.

, 19

(Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery May 15 1928

20 UNDERTAKER

(ADDRESS)

J. F. Elin's Reisterstown, Md

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33681

## CERTIFICATE OF DEATH.

90 E 33681

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals ST. 15-59 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jones(a) RESIDENCE NO. 2417 Stockton st.ST. Unknown WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Singlea If married, widowed, or divorced  
HUSBAND of  
or WIFE ofDATE OF BIRTH (month, day, and year) 1873AGE Years Months Days If LESS than 1 day, hrs. or min. 55

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Maryland  
(State or country)10 NAME OF FATHER Fred Jones11 BIRTHPLACE OF FATHER (city or town) Virginia  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Virginia  
(State or country)14 Informant Hospital Records  
(Address)15 Filed 1828 19 1928 JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1928 to May 5, 1928that I last saw him alive on May 5, 1928and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis with myocardial insufficiency.(duration) Unknown yrs. mos. ds.CONTRIBUTORY Broncho-pneumonia  
(Secondary)(duration) 2 yrs. mos. ds.18 Where was disease contracted Unknown  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Clinical & autopsy(Signed) L. E. Mathew, M. D.5-5-1928 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MT auburn5/8 1928

UNDERTAKER

ADDRESS

Virginia A Brooks 1463 Carey St





E 33683

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

170 E 33683

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Stafford Hotel St. 14 Ward) 202-FULL NAME William Bowie Mackenzie(a) RESIDENCE NO. 1404 Park Ave

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. 3 mos. 7 ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 23 yrs. 3 mos. 7 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 Color or Race <u>White</u>	5 Single, Married, Widowed, or Divorced, (write the word) <u>Married</u>
----------------------	---------------------------------	---

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofMargaret F. Cornman Mackenzie

6 DATE OF BIRTH (month, day, and year)

January-31-1901

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	<u>27</u>	<u>3</u>	<u>7</u>	<u>6</u>

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....Writer(b) General nature of industry, business, or establishment in which employed (or employer).....Writing(c) Name of employer.....Self9 BIRTHPLACE (city or town).....Baltimore  
(State or country).....Maryland10 NAME OF FATHER John P. Mackenzie11 BIRTHPLACE OF FATHER (city or town).....Baltimore  
(State or country).....Maryland12 MAIDEN NAME OF MOTHER Mary S. Rice13 BIRTHPLACE OF MOTHER (city or town).....Hillsboro  
(State or country).....Va.14 Informant Mr. H. M. Robertson (brother-in-law)  
(Address) 535-5th Ave., New York City, N.Y.15 Filed 1928 HAMPSON JONES, M. D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7-192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....inquest  
(Inquest, au-  
topsy or inquiry.) And that said deceased came to.....his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

suicide by pistol shot  
in the brain

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY

(Secondary)

(Signed) W. H. Jones .....yrs. ....mos. ....ds.  
(Coroner) M. D.  
May 8 1928 Address 1059 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....0 yrs. 0 mos. 2 ds. In the State.....yrs. ....mos. ....ds.Where was disease contracted, if not at place of death?.....Stafford HotelFormer or usual residence 1404 Park Ave.

PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Greenmount CemeteryMay-8-2820 UNDERTAKER STEWART & MOWEN COMPANY

ADDRESS

(WILLIAM F. WOODEN, Successor)108 W. NORTH AVE

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33684

## CERTIFICATE OF DEATH.

REGISTERED NO. 33684

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 12-44 Mercy HospitalSt. 12-44 Ward2-FULL NAME Margaret Frances Cornman MacKenzie(a) RESIDENCE NO. Mercy Hospital

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 20 yrs. 2 mos. 18 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofWilliam Bowie MacKenzie

6 DATE OF BIRTH (month, day, and year)

February-11-1908

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

20

2

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

None

(c) Name of employer.....

None

9 BIRTHPLACE (city or town) Carlisle

(State or country)

Penna.10 NAME OF FATHER Joseph R. Cornman11 BIRTHPLACE OF FATHER (city or town) Huntington  
(State or country) Penna.12 MAIDEN NAME OF MOTHER Virginia I. Gemmil13 BIRTHPLACE OF MOTHER (city or town) Hanover  
(State or country) Penna.

14

Informant Mr. Joseph R. Cornman (father)  
(Address) Towson, Md.

15

Filed 1926

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, autopsy or inquiry) and that said deceased came to..... death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Homicide.  
Shot wound in brain - said bullet being  
found by hands of her husband W. B. MacKenzie  
(duration)..... yrs. .... mos. .... ds.CONTRIBUTORY  
(Secondary)(Signed) W. B. MacKenzie  
(Coroner)  
1928 (Address) 1629 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 2 weeks 1-hour In the State 6 yrs. 0 mos. 0 ds.Where was disease contracted, if not at place of death? Stafford HotelFormer or usual residence Towson, Md.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Green Mount Cemetery  
UNDETAILED & MOVED COMPANY  
(WILLIAM F. WOODEN, Successor)Date of Burial May/10/1928

ADDRESS

108 W. NORTH AVE.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33685

## CERTIFICATE OF DEATH.

74-001 E 33685  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3410 Edmondson Ave ST. 16-70 WARD)2-FULL NAME Emma J. Hunt

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3410 Edmondson Ave ST. 16-70 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Yrs. yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 ~~Single~~ Married, Widowed, or ~~Divorced~~, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. Hunt6 DATE OF BIRTH (month, day, and year) Apr 25, 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min. 77 4 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md  
(State or country)10 NAME OF FATHER Wm. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md12 MAIDEN NAME OF MOTHER Emma Heritage

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14

Informant Mrs McAllister  
(Address) 3410 Edmondson Ave

15

Filed

HAMPDEN JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1928

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to May 5, 1928, that I last saw her alive on May 4, 1928, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH was as follows:

Arterio-Sclerosis 5 yrs  
Central Hemorrhage 10 daysCONTRIBUTORY (Secondary) Pulmonary Congestion(duration) yrs. mos. ds. 2 ds.18 Where was disease contracted if not at place of death? NoDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Blood pressure test(Signed) J. M. Delworth M. D.(Address) 621 Washington Blvd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park AveDATE OF BURIAL 5/8/28 1920 UNDERTAKER Geo LeimlochADDRESS 5207 Lyndhurst



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33686

CERTIFICATE OF DEATH

46 ✓

E 33686

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *605 N. Chapel* ST., *7-9* WARD)

2—FULL NAME

*Lillie Elie Koen Smith*

(a) RESIDENCE NO.

*605 N. Chapel* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

*F.*

4 COLOR OR RACE

*C.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

If married, widowed, or divorced HUSBAND of (or) WIFE of

*John Smith*

DATE OF BIRTH (month, day, and year)

*unknown 1881*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*47*

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House Wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Isaac Amos*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Mary J. Bryant*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

Informant (Address)

*Marion Chaney 605 N. Chapel St.*

Filed

*1928*

*HAMPTON JONES, JR.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 1, 1928*

17

HEREBY CERTIFY, That I attended deceased from *Nov. 1, 1927* to *May 4, 1928*

that I last saw him alive on

*May 14, 1928*

and that death occurred, on the date stated above, at

*4:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Uterus Indefinite*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

*Phys. & Ex.*

(Signed)

*J. Garland Russell M. D.*

May 8, 1928

(Address) *1534 - Chest Hill*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*Mount Calvary*

*May 8, 1928*

20 UNDERTAKER

*Mrs. R. G. Elliott*

ADDRESS

*1725 Ashland*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33687

## CERTIFICATE OF DEATH.

31 E 33687

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital 15-24 Ward)2-FULL NAME Willie Jones(a) RESIDENCE NO. 1308 Panola St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Mary Jones (or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year) July 6, 19047 AGE 23 Years 10 Months 1 Days IF LESS than 1 day.....hrs. or.....min.8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employee) \_\_\_\_\_

(c) Name of employer General9 BIRTHPLACE (city or town) Cornton W Va (State or country) \_\_\_\_\_10 NAME OF FATHER William Jones11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country) \_\_\_\_\_12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country) \_\_\_\_\_14 Informant Mary Jones (Address) 1308 Panola Alley

15 Filed....., 19 \_\_\_\_\_ Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 192817 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)hereon and from the evidence obtained by said Inquest and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia (duration) \_\_\_\_\_ mos. 1 ds.CONTRIBUTORY (Secondary) Cholera (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds. (Address) 143 N. Bray

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of burial May 8 192820 UNDERTAKER James E. Wright ADDRESS 1364 N. Mary

E 33688

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33688  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16476 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cleveland Robinson(a) RESIDENCE NO. 1014 Edmonson Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE Caucasoid 5 Single, Married, Widowed, or Divorced, (write the word) marriedIf married, widowed, or divorced  
HUSBAND of  
or) WIFE of Hettie RobinsonDATE OF BIRTH (month, day, and year) 1891AGE Years Months Days If LESS than 1 day, hrs. or min. 57

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work carver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Robert Robinson11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER ?13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 BALTIMORE CITY HOSPITAL Informant (Address) Records15 Filed 8.19.1928 HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17-192817 I HEREBY CERTIFY, That I attended deceased from April 24, 1928 to May 7, 1928 that I last saw him live on May 7, 1928 and that death occurred, on the date stated above, at 9.20 A. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis, chronic & acute  
arteriosclerosis  
hypertension

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? General & Sub(Signed) C. Cleveland Burd M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-BURIAL

DATE OF BURIAL

Mr. Arthur May 9 1928

20 UNDERTAKER

ADDRESS

Samuel Wright 1264 Mary

# Askeu - HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33689

## CERTIFICATE OF DEATH.

90 E 33689

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 108 Colvin

St. 5-8 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 108 Colvin

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14

Informant  
(Address)

15

Filed

1928

C. H. HARRISON

JONES

M. D.

Registrar

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1928

17 I HEREBY CERTIFY that I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-topsy, or inquiry.) and that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)(duration) yrs. mos. ds.  
M. D.

(Corener)

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER ADDRESS



E 33690

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. 167 E 33690

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 7-9 Ward)2-FULL NAME Mrs. Flora Lofting(a) RESIDENCE NO. Elizabeth, N.J.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofHugh Lofting

6 DATE OF BIRTH (month, day, and year)

Dec 4 - 18807 AGE 47 Years 5 Months 2 Days IF LESS than  
1 day.....hrs.  
or.....min. 40

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

New York City.10 NAME OF FATHER Martin Swall11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Holokui N Y12 MAIDEN NAME OF MOTHER Lida White13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany14 Informant Hopkins Records  
(Address)15 Filed 8-19-28 HAMPTON JONES, M.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6/2817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy, or inquiry.)  
thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above.  
(Inquest, autopsy, or inquiry.)

The CAUSE OF DEATH\* was as follows:

Barbital Poisoning- Probable Suicide  
(Clinical)CONTRIBUTORY  
(Secondary)(Signed) J. H. Vatter M. D.  
(Coroner)(Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cremation Date of Burial 5-8-2820 UNDERTAKER London Park Cem ADDRESS Orchard  
Chas W. Jones, Sons & Co Inc

33691 T-1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH *South - Water Sts.*

CITY OF BALTIMORE: (No. *Canton House* ST. *4-6* WARD)

2-FULL NAME *Catherine Thomas*

(a) RESIDENCE NO. *South Water*  
(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *0* mos. *0* ds.

ST. *4* WARD *6*

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John Thomas*

6 DATE OF BIRTH (month, day, and year) *February 12, 1946*

7 AGE Years Months Days *82* *2* *25* If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Carroll County, Maryland*  
(State or country)

10 NAME OF FATHER *Not known*

11 BIRTHPLACE OF FATHER (city or town) *Not known*  
(State or country)

12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (city or town) *Not known*  
(State or country)

14 Informant *John Thomas*  
(Address) *South Water Sts. City*

15 Filed *8-19-28* *19* *HAMMON JONES, M. D.* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 7, 1928*

17 I HEREBY CERTIFY, That I attended deceased from *April 25, 1928* to *May 7, 1928*  
that I last saw her alive on *May 6, 1928*

and that death occurred, on the date stated above, at *4:09 P. M.*  
The CAUSE OF DEATH\* was as follows:

*Cerebral apoplexy*

(duration) yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical symptoms*  
(Signed) *Allen Beetham* M. D.  
*5-7, 1928* (Address) *3139 E. Baltimore St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Tarmeytown Ind*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*William Cook*

*5/10 1928*  
*5024 North*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33692

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 33692

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2668 Penn Ave St. 15-59 Ward 6)

## 2-FULL NAME

(a) RESIDENCE NO. 2668 Penn

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie M. Alexander6 DATE OF BIRTH (month, day, and year) June 16, 18767 AGE Years 51 Months 10 Days 20 IF LESS than 1 day...hrs. or...min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) N. Carolina10 NAME OF FATHER John M. Alexander

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.12 MAIDEN NAME OF MOTHER Mary Henderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

## PARENTS

14 Informant Mrs. Elsie M. Alexander  
(Address) 2418 Callow Ave.15 Filed 1928 HAMMON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 192817 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest and that said deceased came to this death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide  
Gas Poisoning 3th.  
(duration) Asphyx yrs. mos. 6th

## CONTRIBUTORY (Secondary)

may 8 1928 (duration) yrs. mos. 6th  
(Signed) Geo. C. Hays M. D.  
(Coroner)  
715 (Address) 143 161 Eway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death...yrs. mos. ds. In the State...yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lorraine Park Cemetery Date of Burial May 8 1928

## 20 UNDERTAKER

John D. Lenny ADDRESS 715 Light St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33693

## CERTIFICATE OF DEATH.

\* 159-001 E 33693

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hosp* ST. *17-41* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *David Schaback*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *8*mos. *24*

ds.

How long in U. S., if of foreign birth?

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*M.*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*Aug 13, 1927*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*8**24*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

*Leonard Schaback*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balt.*

12 MAIDEN NAME OF MOTHER

*Mary Ellen Smith*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Sharon Md.*

14

Informant (Address)

*Mother*

15

Filed *8-1928*

C. H. JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 7 1928*

17

I HEREBY CERTIFY, that I attended deceased from *April 8, 1928* to *May 7, 1928*.

that I last saw him alive on

*May 7, 1928*

and that death occurred, on the date stated above, at

*2:10 pm.*

The CAUSE OF DEATH\* was as follows:

*Hydrocephalus*(duration) yrs. *8* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *10* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *May 7, 1928*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *F. J. Seragity* M. D.19 (Address) *Union Memorial Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St Charles Cem. Pikesville Md.**May 8 1928*

UNDERTAKER

ADDRESS

*Chas. H. Jones & Son 118 W. 1st St. Baltimore*



# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL*)

### 2-FULL NAME

*Thomas Butera*

### (a) RESIDENCE NO.

*1041 N. Milton Ave.*

Length of residence in city or town where death occurred *15* yrs. mos. ds.

ST. *8-12*

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male*

*White*

*Married*

If married, widowed, or divorced HUSBAND of (or) WIFE of

*Camelia Butera*

DATE OF BIRTH (month, day, and year)

*1893*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*37*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Italy*

10 NAME OF FATHER

*George Butera*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Italy*

12 MAIDEN NAME OF MOTHER

*Galuney*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Italy*

14

Informant (Address)

*Records*

15

Filed

19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr. 25, 1928, to May 6, 1928,*

that I last saw him alive on *May 6, 1928,*

and that death occurred, on the date stated above, at *3:00 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Hepatitis*

*about*

(duration) *14* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Syphilis*

(duration) *about 12* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*1941 N. Milton Ave*

Did an operation precede death?

*No*

Was there an autopsy?

*yes*

What test confirmed diagnosis?

*Kidney Tissue Tests.*

(Signed)

*James Brindley*

M. D.

5/7, 1928 (Address)

*Johns Hopkins Hospital.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Soly Redeemer*

20 UNDERTAKER

*Geo J. Ruth 1735 Harford Ave*

DATE OF BURIAL

*5/9 1928*

ADDRESS

E 33695

## HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001 E 33695

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

female

negro

6-DATE OF BIRTH

November

6, 1925

(Month)

(Day)

(Year)

7-AGE

2

yrs.

6

mos.

1

ds.

If LESS than  
1 day, ....hrs.  
or min.?

8-OCCUPATION

(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9-BIRTHPLACE

(State or country)

Baltimore Md

PARENTS

10-NAME OF  
FATHER

James Barnett

11-BIRTHPLACE  
OF FATHER  
(State or country)

Baltimore Md

12-MAIDEN NAME  
OF MOTHER

Annabel Hall

13-BIRTHPLACE  
OF MOTHER  
(State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank J. Ayde

(Address)

2005 E. Monument St

15

Filed

191

HARRISON JONES, M.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

7

(Month)

(Day)

1928

(Year)

17- I HEREBY CERTIFY, That I attended deceased from  
May 3, 1928, to May 6, 1928,that I saw her alive on May 6, 1928,  
and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration)

yrs.

mos.

4

ds

Contributory  
(SECONDARY)

Acute Myocarditis

(Duration)

yrs.

mos.

2

ds

(Signed),

Frank J. Ayde

M. D.

May 7, 1928.

(Address) 2005 E. Monument St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place  
of death

yrs.

mos.

In the

ds.

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery

5-9

1918

20-UNDERTAKER

T. E. Kelson

ADDRESS

1300 Pratt St

is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33696

## CERTIFICATE OF DEATH.

46 E 33696

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 N. Monroe

ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aimee Lillian Ella Whiteside

(a) RESIDENCE NO. 1924 N. Monroe St

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word) Single

Female White

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28 1884

7 AGE 43

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

4

7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Dress maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Samuel Whiteside

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Sarah Ella Crist

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Frederick Maryland

14

Informant (Address)

Belle Whiteside 1924 N. Monroe St

15

Filed

MAY 3 - 1928

Per

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1928

17

I HEREBY CERTIFY, That I attended deceased from Dec 2, 1927, to May 5, 1928, that I last saw him alive on May 5, 1928, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH\* was as follows:

Sarcoma of Left Breast (4 mo)  
Generalized Sarcomatosis  
Metastasis (4 mo)  
Secondary anemia 6 mo.  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 1927

Was there an autopsy? No

What test confirmed diagnosis? Histological.  
(Signed) J. W. H. M. D.

5/7, 1928 (Address) 846 N. 1st St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

LONDON PARK CEM

20 UNDERTAKER

May 8 1928

ADDRESS

1003 West Baltimore St

E 33697

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33697

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. W. Balto. G. Hosp. 21-29 Ward)2-FULL NAME Lydia Connors(a) RESIDENCE NO. 914 Burgumby St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced Single  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18747 AGE Years 54 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)10 NAME OF FATHER Geo Connors11 BIRTHPLACE OF FATHER (city or town) Balto. Md.  
(State or country)12 MAIDEN NAME OF MOTHER Annie Kahler13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.  
(State or country)14 Informant Julia Murphy  
(Address) 8914 Burgumby St.15 Filed 1928 HANCOCK Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3<sup>rd</sup> 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest  
(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Uterus  
(duration) 3 yrs. 3 mos. 3 ds.CONTRIBUTORY  
(Secondary)(duration) 3 yrs. 3 mos. 3 ds.

(Signed)

May 6<sup>th</sup> 1928  
(Address)J. B. Lank M. D.  
Coroner.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Ave Date of Burial May 8<sup>th</sup> 192820 UNDERTAKER Joseph J. Cook ADDRESS 1003 Balto.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33698

## CERTIFICATE OF DEATH

E 33698

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital*St. *7-12* Ward)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Edward Sala*(a) RESIDENCE NO. *915 N. Rose St*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S. if of foreign birth? *20* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 Color or Race

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Concetta Sala*

6 DATE OF BIRTH (month, day, and year)

*Not known*

7 AGE

Years

Months

Days

IF LESS than 1 day...hrs. or...min..

*53*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Tailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*I. Italy*

10 NAME OF FATHER

*Salvador Sala*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Italy*

12 MAIDEN NAME OF MOTHER

*Esther Garcia*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Italy*

14

Informant

(Address)

*Esther Garcia**915 N. Rose St*

15 Filed

C. 19

*HARRISON JONES*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/6/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*3/5/28*, 19, to *5/6/28*, 19.that I last saw him alive on *5/6/28* at *10:58* p.m.and that death occurred, on the date stated above, at *10:58* p.m.

The CAUSE OF DEATH\* was as follows:

*Lung Abscess*(duration) *2 1/4* yrs. mos. da.

CONTRIBUTORY

(Secondary)

*Toxemia*(duration) *2 1/4* yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *4/17/28*

Was there an autopsy?

What test confirmed diagnosis?

*Operation*

(Signed)

, 19

(Address)

*J. J. Whitehead M. D.*  
*Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Holy Redeemer**May 9 1928*

20 UNDERTAKER

ADDRESS

*Frank Buchanan**1806 Calvert St*

very important. See instructions on back of card.

Y 8 - 1928

E 33699

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33699

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2029 Gough

St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY RUTKOWSKI,

(a) RESIDENCE NO. 2029 Gough

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 54 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female, White, Widow,

5a If married, widowed, or divorced HUSBAND of Frank Rutkowski, (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE Years Months Days IF LESS than 1 day hrs. or min.. About 80

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Poland,

10 NAME OF FATHER

Unknown,

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Poland,

12 MAIDEN NAME OF MOTHER

Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland,

14 Informant Joseph Rutkowski,

(Address) 312 S. Ann St

15 Filed 8-1928 C. HARRISON JONES M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

May 3<sup>rd</sup>, 1928, to May 7<sup>th</sup>, 1928,that I last saw him alive on May 7<sup>th</sup>, 1928,

and that death occurred, on the date stated above, at 2:40 P. M.

The CAUSE OF DEATH\* was as follows:

Senility

Bedridden (duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J. Giering M. D.

May 7, 1928 (Address) 1900 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Stanislaus

Date of Burial

May 10- 1928.

UNDERTAKER

D. M. J. Sadowski

ADDRESS

400 S. Ann St

3779  
E 33700

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33700

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITALST. 76-2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Anna S Hunt

## (a) RESIDENCE NO.

417 S - Bouldin ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleWhiteMarried6 If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofFrank J. Hunt

7 DATE OF BIRTH (month, day, and year)

May 8 1883

AGE

44 Years

Months

11

Days

29If LESS than  
1 day. hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Ind -

10 NAME OF FATHER

Louis Savers11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Ind -

12 MAIDEN NAME OF MOTHER

Patience Hunt13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Ind -

14

Informant  
(Address)Records -

15

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 7 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 4 1928 to May 7 1928.that I last saw her alive on May 7 1928and that death occurred, on the date stated above, at 2 5-9 a.m.

The CAUSE OF DEATH\* was as follows:

Acute gangrenous appendicitis  
peritonitis, myocardial degeneration  
diabetes mellitus

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

diabetes mellitus, myocardial  
degeneration obesity

(duration) ? yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. L. Faulkner, M. D.19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak Lawn Cemetery May 10 1928

20 UNDERTAKER

Lilly & Ziehl Inc.

ADDRESS

4838 W. 1st St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33701

## CERTIFICATE OF DEATH.

E 33701

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hosp 16-27*)REGISTERED NO. *113*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Charles Kenneth Smith*(a) RESIDENCE NO. *618 - Bruce St*

(Usual place of abode)

ST. *Baltimore*

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *M*4 COLOR OR RACE *W.*

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *April 22, 1928*

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min. *15*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*  
(State or country)10 NAME OF FATHER *Bernard Smith*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Md. Baltimore*12 MAIDEN NAME OF MOTHER *Kelley Jewell*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Md.*

14

Informant: *Mother*  
(Address)

15

Filed

19

G. HAMMON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 7, 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*May 5*, 19*28*, to *May 7*, 19*28*,  
that I last saw him alive on *May 7*, 19*28*,  
and that death occurred, on the date stated above, at *10.05 A.M.*

The CAUSE OF DEATH\* was as follows:

*Malnutrition*

(duration)

yrs.

mos.

ds. *0*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds. *8*18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no*

Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. J. Geraghty*

M. D.

19

(Address) *Union Memorial Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Int. Olivet Cem.**5/8/28*

20 UNDERTAKER

ADDRESS

*Harry W. Wike**1031 W. Lombard St*



33702

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 33702

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baldy City Hosp. 24-33* ST. *WARD*)2-FULL NAME *William H. Henning*(a) RESIDENCE NO. *1107 Battery ave.*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**white**Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *Nov 30 1879*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*48 -**5**7*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Painter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*Charles Henning*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*MD*

12 MAIDEN NAME OF MOTHER

*Maggie Schantz*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Maryland*

14

Informant  
(Address)*Mrs. Maggie Schantz  
1107 Battery Ave*

15

Filed

19

*C. HAMPSON JONES, M. D.*  
*Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-7 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*5-3-1928 to 5-7-1928*that I last saw him alive on *5-7-1928*and that death occurred, on the date stated above, at *10:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Stenocardia, Chronic  
myocarditis, Acute alcoholism  
Chronic tubercular nephritis  
(duration) *unknown**CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?*Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

*Physical Laboratory  
Baltimore M. D.*

(Signed)

, 19

(Address)

*Baldy City Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Cedar Hill**May 10 1928*

20 UNDERTAKER

ADDRESS

*John F. Dennis**715 L St SE*

33703

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33703

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin Sq. Hospital 9-27* St. *166* Ward)

Registered No. C. ....

## 2-FULL NAME

*Hiram H. Brown*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Unknown* St.; yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Male*

4-COLOR OR RACE,

*White*5-Single, Married, Widowed, or Divorced, (Write the word.) *NK*

6-DATE OF BIRTH,

(Month) (Day) (Year) *1887*

7-AGE,

*60*

yrs. .... mos. .... ds.

If LESS than 1 day,

hrs. or .... min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer).

*NK* *087*

9-BIRTHPLACE,

(State or Country).

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country), *Not known*

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

1928 C. HAMPTON JONES, M. D.

Per

*RFH*

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Apr 25* 1928  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquiry* (Inquest, au-topsy or inquiry.) find that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH<sup>1</sup> was as follows:*Suicide**Hg. 662*

CONTRIBUTORY (Secondary)

*As exhaustion*

(Duration)

*6 mos.*

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place

of death.

yrs. .... mos. .... ds.

In the

State.

yrs. .... mos. .... ds.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place

of death.

yrs. .... mos. .... ds.

In the

State.

yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

UNIVERSITY OF MARYLAND

20-UNDERTAKER,

ADDRESS

Commissioner Health.

MAY 8 - 1928

212 THE MORGUE

FOR AM F BUREAU

E 33704

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33704

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL* ST., *7-9* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Sturdivant*(a) RESIDENCE No. *1635 McElderry* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**Black*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.*1*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Ind -*

10 NAME OF FATHER

*James Sturdivant*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Ind -*

12 MAIDEN NAME OF MOTHER

*Mary*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Ind -*

14

Informant

(Address)

*Records -**JOHNS HOPKINS HOSPITAL**JOHNS HOPKINS HOSPITAL*

15

Filed

*1928**C. HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 6 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*May 5 - 1928 to May 6, 1928.*that I last saw her alive on *May 6, 1928*and that death occurred, on the date stated above, at *12:45 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pre-maturity*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?*1*Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*H. C. Goodwin*

M. D.

19

(Address)

*JOHNS HOPKINS HOSPITAL*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

*Commissioner of Health.**MAY 8 - 1928*

33705

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33705

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital, Baltimore, Md. WARD)

## 2-FULL NAME

George Downey

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 234 Pavillion Ave.,  
(Usual place of abode) Providence, R.I.Length of residence in city or town where death occurred 2 yrs. 6 mos.

ST., WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) marriedIf married, widowed, or divorced  
HUSBAND of  
or) WIFE of M. DowneyDATE OF BIRTH (month, day, and year) Feb. 15, 1867AGE Years Months Days If LESS than 1 day, hrs. or min.  
61 2 22

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain(b) General nature of industry, business, or establishment in which employed (or employer) Seaman(c) Name of employer Tug Winthrope9 BIRTHPLACE (city or town) Maryland  
(State or country)10 NAME OF FATHER John Downey11 BIRTHPLACE OF FATHER (city or town) Kent Co. Md.  
(State or country)12 MAIDEN NAME OF MOTHER Mary E. Vickers13 BIRTHPLACE OF MOTHER (city or town) Kent Co., Maryland  
(State or country)14 Informant Records, U.S. Marine Hospital  
(Address)15 C. HAMPSON JONES, M. D.  
19 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
Oct. 10, 19 25, to May 7, 19 28.that I last saw him alive on May 7, 19 28.and that death occurred, on the date stated above, at 1:25 a.m.

The CAUSE OF DEATH\* was as follows:

Hemiplegia, left side Apoplexy, cerebral hemorrhage(duration) 2 yrs. 8 mos. ds.CONTRIBUTORY Nephritis, parenchymatis, chronic  
(Secondary) Myocarditis, chronic, general(duration) 2 yrs. 8 mos. ds.18 Where was disease contracted  
if not at place of death? on board shipDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? physical examination(Signed) J. C. Jones M. D.19 (Address) U.S. Marine Hospital, Balto.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Oliver's CemMay 9, 1928

20 UNDERTAKER

ADDRESS

Wm J. Glickner, Son78 Pa



33706

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33706

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

BALTIMORE CITY HOSPITAL ST. 18-76 WARD

2-FULL NAME *William J. Davis*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *1031 W. Fayette* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*male*

*white*

*single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*52*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Painter*

(b) General nature of industry, business, or establishment in which employed (or employer)

*050*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

?

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

?

14

Informant (Address)

*Records*

Filed

1928

C. HAMPSON JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/8/1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Oct 21, 1925*, to *May 7, 1928*

that I last saw him alive on *May 4, 1928*

and that death occurred, on the date stated above, at *6:00 P. M.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary tuberculosis*

(duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

*General + Lab*  
(Signed) *C. H. Jones*, M. D.  
19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Sacred Heart*

DATE OF BURIAL

*5/8 1928*

20 UNDERTAKER

*J. J. Taber & Sons*

ADDRESS

*1318 Light St*

33707

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33707

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 15-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles O'Donnell

(a) RESIDENCE NO. Unknown  
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos.

ST. 15-37 WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of or WIFE of

DATE OF BIRTH (month, day, and year) 1856

AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Delaware

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records

15 Filed 1928 HAMMON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1928

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1928, to May 6, 1928, that I last saw him alive on May 6, 1928, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Talbot, M. D.

5-6-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sacred Heart

20 UNDERTAKER

19

J. J. Talbot & Sons

ADDRESS

1318 Light St

33708

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33708

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Street *Chapman*

CITY OF BALTIMORE: (No. 3726 Park Heights

ST.

WARD)

2-FULL NAME

Santa Azzarelli

(a) RESIDENCE No.

3726 Park Heights Ave

(Usual place of abode)

Length of residence in city or town where death occurred

50

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Nathaniel Azzarelli

6 DATE OF BIRTH (month, day, and year)

Sept 15/72

7 AGE

55

Years

7 Months

20 Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Fruit

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Dealer

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Italy

10 NAME OF FATHER

Salvatore Azzarelli

11 BIRTHPLACE OF FATHER (city or town)

Italy

(State or country)

12 MAIDEN NAME OF MOTHER

M. Graziano

13 BIRTHPLACE OF MOTHER (city or town)

Italy

(State or country)

14

Informant  
(Address)Mrs. Nathaniel Azzarelli  
3726 Park Heights Ave

15

Filed

1928

HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 5 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 10 1928, to May 5 1928,  
that I last saw him alive on May 5 1928,

and that death occurred, on the date stated above, at 2:55 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis  
chronic

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Mycobacterium tuberculosis

(duration)

15 yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests  
(Signed) Frank Stewart, M. D.

May 5, 1928 (Address) Church Street Chapman

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Holy Redeemer Church

May 8 1928

20 UNDERTAKER

(ADDRESS)

J. P. Puth 1735 Lafayette Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33709

## CERTIFICATE OF DEATH

31 E 33709

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1826 C Lombard St 2-4 Ward)

2-FULL NAME Mary W.A. Schramm

(a) RESIDENCE NO. 1826 C Lombard St. Ward

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day... hrs.  
or... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14 Informant  
(Address)

15 Filed

8-1928

C. HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7/1928

17 I HEREBY CERTIFY, That I attended deceased from  
Sept 1927 to May 7, 1928.  
that I last saw him alive on May 7, 1928.  
and that death occurred, on the date stated above, at 11:57 m.  
The CAUSE OF DEATH\* was as follows:CONTRIBUTORY  
(Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS





# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33711

E 33711

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 421 Wellington Lane ST. 10-69 WARD)

### 2-FULL NAME

(a) RESIDENCE No. 421 Wellington Lane ST. 10-69 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John Burns

DATE OF BIRTH (month, day, and year) June 12, 1852

AGE Years 75 Months 10 Days 26 If LESS than 1 day, 0 hrs. 0 min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Informant (Address) Dr. J. Steffe

15

Filed 1928 C. 19 HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from February 1, 1928 to May 6, 1928, that I last saw him alive on May 6, 1928, and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH\* was as follows:

General debility  
Arterio-sclerosis, Endocarditis.

CONTRIBUTORY (Secondary)

(duration) Unknown yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Chemical

(Signed) Robert E. White, M. D.

(Address) 2101 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Lansdown Park Cemetery May 9<sup>th</sup> 1928  
F. B. Wappert, 1504 H. Balto St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33712

## CERTIFICATE OF DEATH.

146 E 33712

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Provident Hospital 23-31* Ward)2-FULL NAME *May E. Gough*(a) RESIDENCE NO. *26 W. Cross* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *28* yrs. *3* mos. *1* ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 Color or Race *Col* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Edw. Gough* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Jan 18 - 1899*7 AGE *29* Years *28* Months *3* Days *1* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Homework*(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER  *Jas E. Miller*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country)12 MAIDEN NAME OF MOTHER *Carrie Bayall*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)14 Informant *Edw. Gough* (Address) *26 W. Cross*15 Full Name *C. HAMPTON JONES, M. D.* Registrar

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 6 1928*17 I HEREBY CERTIFY, That I am in charge of the remains described above, held at *Autopsy* (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said *Autopsy* (Inquest, autopsy or inquiry.)And that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*General Peritonitis*

## CONTRIBUTORY (Secondary)

*Sepsis Metastasis**Feb. 28* (Coroner)*May 28* (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

In the place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL *MT. Auburn* Date of Burial *5/10/1928*20 UNDERTAKER *Mrs. H. Holland* ADDRESS *163 Duval St. S.E.*

33713

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33713

## CERTIFICATE OF DEATH. X 74-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 W. Lanvale 16-22

ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Mary Blackwell

(a) RESIDENCE NO. 1533 W. Lanvale

(Usual place of abode)

ST. WARD South Carolina

Length of residence in city or town where death occurred

yrs. 6 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female colored  
If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Elijah Blackwell

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

49

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

S. C.

10 NAME OF FATHER

Clayton Horwath

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

S. C.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)Agnes McElroy  
1533 W. Lanvale St.

15

Filed

HAMPSON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 6 19 28

17

I HEREBY CERTIFY, That I attended deceased from

May 4 19 28 to May 6 19 28

that I last saw him alive on May 6 19 28

and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

C. J. Riggs, M. D.

877, 19 28 (Address) 1536 W. Lanvale St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Auburn

DATE OF BURIAL

5/10/19 28

20 UNDERTAKER

Mrs. Geo. H. Holland, 631 Dundas Hwy



(Mason)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33714

E 33714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1319 Argyle av

CITY OF BALTIMORE: (No.)

ST. 17-24 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Mason

(a) RESIDENCE No. 1319 Argyle av  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Blk 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Helen

DATE OF BIRTH (month, day, and year) March 27/83

AGE 45 Years 1 Months 10 Days 1 LESS than day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Western Ind Dairy

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Helen Mason (Address) 1319 Argyle av

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6 1928

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1928, to May 6th, 1928, that I last saw him alive on May 5, 1928, and that death occurred, on the date stated above, at 9:45 A. m. The CAUSE OF DEATH\* was as follows:

Pyelitis Cystitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Uræmia

(duration) yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical (Signed) Gustav W. M. D. (Address) 656 Franklin Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mt. Auburn

DATE OF BURIAL 5/9/1928 ADDRESS

UNDERTAKER Mr. Geo. H. Holla 1627 Duval St

E 33715

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33715

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 Forrest ST., 58 WARD)

2—FULL NAME Stephen Ruffin

(a) RESIDENCE NO. 709 Forrest ST., 58 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 0 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie

DATE OF BIRTH (month, day, and year) Feb. 1900

AGE 28 Years 2 Months 3 Days If LESS than 1 day, 0 hrs. 0 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Carra. R. R.

BIRTHPLACE (city or town) (State or country) Mcbean Georgia

10 NAME OF FATHER Godfield Ruffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Maggie Ruffin (Address) 709 Forrest

Filed 19 28 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8/28

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1928, to May 8, 1928, that I last saw him alive on May 7, 1928, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY Cardiac hypertrophy (Secondary) (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? AS McCard

(Signed) AS McCard, M. D.

18, 1928 (Address) 2005 N. Hill Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mcbean Georgia

DATE OF BURIAL 5/10/1928

20 UNDERTAKER Joe T. H. Rochester ADDRESS 432 Jefferson

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**E 33716**  
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital, Baltimore, Md. ST. 14-20 WARD)

2-FULL NAME Walter Russell

(a) RESIDENCE No. 1401 Myrtle Ave.,

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? 5 yrs. 7 mos. 28 ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 3, 1903

AGE Years 24 Months 10 Days 3 If LESS than 1 day... hrs. or... min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Second Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer

BIRTHPLACE (city or town) Jamaica (State or country)

10 NAME OF FATHER Adolphus Russell

11 BIRTHPLACE OF FATHER (city or town) Jamaica (State or country)

12 MAIDEN NAME OF MOTHER Johanna Williams

13 BIRTHPLACE OF MOTHER (city or town) Jamaica (State or country)

14 Informant: Records, U.S. Marine Hospital (Address)

15 Filed: 1928 MAY 10 H. JONES, M.D. Registrar

**E 33716**  
REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 19 28

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 19 26, to May 6, 19 28.

that I last saw him alive on May 6, 19 28, and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH\* was as follows: Tuberculosis, pulmonary, chronic, active

(duration) 2 yrs.  mos.  ds.

CONTRIBUTORY Empyema (Secondary)

(duration) 1 yrs.  mos.  ds.

18 Where was disease contracted Tampa, Fla. if not at place of death?

Did an operation precede death? yes Date of 2-15-28

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings, examination of sputum & x-ray examinations (Signed) H. JONES, M.D.

19 (Address) U.S. Marine Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Laurel Egan  
Edith Stiffles

May 9, 1928  
255 North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33717

## CERTIFICATE OF DEATH

44 E 33717

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *2429 Callan ave* ST. *13-59* WARD)2—FULL NAME *Jannie Feinberg*(a) RESIDENCE NO. *2429 Callan ave* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *38* yrs. mos. ds.How long in U. S., if foreign birth *38* yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*If married, widowed, or divorced  
HUSBAND of *Pinus Feinberg*  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *Jan 1st 1928*AGE Years *66* Months *—* Days *—* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Russia*  
(State or country)10 NAME OF FATHER *Mendel L. Brodel*11 BIRTHPLACE OF FATHER (city or town) *Russia*  
(State or country)12 MAIDEN NAME OF MOTHER *Sarah W. Levin*13 BIRTHPLACE OF MOTHER (city or town) *Russia*  
(State or country)4 Informant *M. Feinberg*  
(Address) *2429 Callan ave*5 Filed *9-19-28* 19 *28* *C. H. JONES, M.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9th 1928*17 I HEREBY CERTIFY, That I attended deceased from *Jan 5th*, 19 *28*, to *May 9th*, 19 *28*.that I last saw him alive on *May 9th*, 19 *28*.and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Liver*(duration) *3* yrs. mos. ds.CONTRIBUTORY (Secondary) *Pulmonary Disease*(duration) *1/2* yrs. mos. ds.18 Where was disease contracted ?  
if not at place of death?Did an operation precede death? *24* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical finding*(Signed) *Michael D. Stamps*, M. D., 19 (Address) *2360 Cummins*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Hebrew Cemetery*DATE OF BURIAL *5/9/28*20 UNDERTAKER *Jack Lewis 1439*ADDRESS *1439*



E 33718

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

43 E 33718  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 904 S. Ellwood Ave. St. 1-1 Ward)

2-FULL NAME James H. Billups

(a) RESIDENCE NO. 904 S. Ellwood Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or  
Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Mary Billups

6 DATE OF BIRTH (month, day, and year)

Oct. 1, 1851.

7 AGE

Years

Months

Days

76

7

5

IF LESS than  
1 day—hrs.  
or—min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Captain Steam Ship

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Virginia

10 NAME OF FATHER

John M. Billups

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant  
(Address)

Mrs. Mary Billups

904 S. Ellwood Ave.

15

C. H. JONES, M. D.  
1920 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

May 6 - 1928

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 1, 1927, to May 6, 1928.

that I last saw him alive on May 5, 1928.

and that death occurred, on the date stated above, at 3:41 p.m.

The CAUSE OF DEATH\* was as follows:

Sarcoma of  
jaw and neck

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

May 8 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) Whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

London Park

Date of Burial

May 9 1928

20 UNDERTAKER

Harry B. Witzke 1531 N. Lombard St.

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33719

## CERTIFICATE OF DEATH.

90 E 33719

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 W. Cross St. ST. 21 WARD)

2. FULL NAME Henry Reibert

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1006 W. Cross St. ST. 21 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Martha Reibert

DATE OF BIRTH (month, day, and year) Jan. 14 1849

AGE Years 79 Months 3 Days 16 If LESS than 1 day... hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Henry Reibert

11 BIRTHPLACE OF FATHER (city or town) (State or country) germany

12 MAIDEN NAME OF MOTHER Elix Hendricks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) germany

14 Informant Martha Dittmar Reibert. (Address) 1006 W. Cross St.

15 Filed 9-19-28 C. HAMPTON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1928

17

I HEREBY CERTIFY, That I attended deceased from Feb 12 1928 to May 5 1928, that I last saw him alive on May 5 1928,

and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH\* was as follows:

Aortic Insufficiency.

~~XXXXXXXXXX~~

(duration) 5 yrs. mos. ds.

CONTRIBUTORY Cardiac Asthenia

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

(Address) 1126 W. Cross St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cemetery 9 1928

20 UNDERTAKER

ADDRESS

for foerden's Son 2178 Penn

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 33720**

## CERTIFICATE OF DEATH.

118-002

**E 33720**

1-PLACE OF DEATH *University Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *4-20*)

ST. *4-20* WARD)

2-FULL NAME *Christine M. Maxwell*

(a) RESIDENCE NO. *Severna Park Md.*

ST. *Severna Park-Md.* WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *0* yrs. *0* mos. *2* ds. How long in U. S., if of foreign birth? *1* - yrs. *1* - mos. *1* - ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*

DATE OF BIRTH (month, day, and year) *April 7-1927*

AGE Years *1* Months *1* Day *1* If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer) *none*

(c) Name of employer *none*

9 BIRTHPLACE (city or town) *Balto* (State or country) *Maryland*

10 NAME OF FATHER *Geo. Maxwell*

11 BIRTHPLACE OF FATHER (city or town) *Belfast* (State or country) *Ireland*

12 MAIDEN NAME OF MOTHER *Christine Murdoch*

13 BIRTHPLACE OF MOTHER (city or town) *Bonnyrigg* (State or country) *Scotland*

14 Informant *Geo. Maxwell (Father)* (Address) *Severna Park-Md.*

15 Filed *May 3-1928* HARRISON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/8* 19*28*

17 I HEREBY CERTIFY That I attended deceased from *5/6* 19*28* to *5/8* 19*28*

that I last saw her alive on *5/8* 19*28*

and that death occurred, on the date stated above, at *5/8 4 a.m.*

The CAUSE OF DEATH\* was as follows:

*Intestinal Obstruction*

(duration) yrs mos *4* ds.

CONTRIBUTORY *Accident* (Secondary)

(duration) yrs mos *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *4/7/28*

Was there an autopsy? *no*

What test confirmed diagnosis? *operation* (Signed) *A. V. Finkelstein* M. D.

19 (Address) *University Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Woodlawn Cemetery* *May 9/1928*

20 UNDERTAKER

ADDRESS

*Stewart Mowen Co* *Balto.*

E 33721

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33721

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

Mercy Hospital

23-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Leroy Jeffery

#1411 Race St

(a) RESIDENCE NO.

137 B. Spring St

St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. 0 mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 30/1927

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

1

0

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore, Md.

(State or country)

10 NAME OF FATHER

John L. Jeffery

11 BIRTHPLACE OF FATHER (City or town)

Baltimore

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Sadie B. Layton

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Md.

14

Informant (Address)

Sadie B. Jeffery 1411 Race St

15 Filed

19

HAROLD JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

May 8<sup>th</sup>, 1928

17

I HEREBY CERTIFY, That I attended deceased from

4-29-28, 19, to 5-8-28, 19

that I last saw him alive on May 8<sup>th</sup>, 1928

and that death occurred, on the date stated above, at 1:25 p.m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. Nelson Carey

M. D.

5/8/28

(Address)

Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St Mary's Hospital

May 10/28

20 UNDERTAKER

ADDRESS

Walter Davis

3307 Pine St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33722

## CERTIFICATE OF DEATH.

E 33722

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Annapolis Road Westport* ST. *25-33*)

REGISTERED NO. C

2-FULL NAME *Mary Rowley*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Annapolis Road Westport* St.: yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH, *June 1866*  
(Month) (Day) (Year)

7-AGE, *62* yrs. or min.?  
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Ind.*

10-NAME OF FATHER, *Samuel Hamilton*  
11-BIRTHPLACE OF FATHER (State or Country), *unknown*  
12-MAIDEN NAME OF MOTHER, *Elizabeth Hamilton*  
13-BIRTHPLACE OF MOTHER (State or Country), *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sam Rowley*  
(Address) *Westport*

15-

Filed

MAY 9 - 1928

HAMILTON, JONES, N. D.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 7, 1928*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 1927* 1927, to *May 7* 1928, that I saw him alive on *May 5* 1928, and that death occurred, on the date stated above, at *4:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Leukemia*  
(Duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Raymond J. Sherry* M. D.  
*May 8, 1928* (Address) *Lakeland*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Ambrose**May 9, 1928*

20-UNDERTAKER

ADDRESS *1027*

*John H. Treadwell* *Deer Hill*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33723

## CERTIFICATE OF DEATH.

29 E 33723  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 5 S. Robinson St. 1-2 Ward)2-FULL NAME Philip P. Rizzo(a) RESIDENCE NO. 5 S. Robinson

(Usual place of abode)

Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14

Informant

(Address)

15 Filed

19

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1928

17

I HEREBY CERTIFY That I took charge of the  
remains described above, held an Inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
Inquest, autopsy or inquiry, and that said deceased came to death  
on the day stated above

The CAUSE OF DEATH was as follows:

Acc. Fall  
4 ft. high  
Punch wound  
Stomach  
Duration) yrs. mos. 4 ds.CONTRIBUTORY  
(Secondary)

May 8/28

(Signed)

M. D.

19

(Address)

143 W. Bay

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Cathedral Bury

20 UNDERTAKER

W M Rutter

Date of Burial

May 19-28

ADDRESS

2238 N

Brook

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST. *19-27* WARD)

2-FULL NAME *Evelyn Christy Ames*

(a) RESIDENCE NO. *319 N. Stricker* ST. *19-27* WARD

(Usual place of abode)  
Length of residence in city or town where death occurred *4* yrs. *4* mos. *4* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *F*

4 COLOR OR RACE *C*

5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *April 7-1910*

AGE

Years *18*

Months *1*

Days

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Md*

10 NAME OF FATHER *John Ames*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*

12 MAIDEN NAME OF MOTHER *Ann Ames*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14

Informant (Address) *Lillian Ames*

*319 N. Stricker St*

15

Filed

19

*C. HAMMON JONES, M.D.*

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-7-1928*

17

I HEREBY CERTIFY, That I attended deceased from *4/24/1928*, to *5/7/1928*, that I last saw her alive on *5/7/1928*

and that death occurred, on the date stated above, at *11:00 P.M.*

The CAUSE OF DEATH\* was as follows:

*Tuberculosis of spine joint.*

(duration) *6* yrs. *6* mos. *6* ds.

### CONTRIBUTORY (Secondary)

*Stroke (Hemiplegia)* (duration) *1* yrs. *1* mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *5/7/28*

Was there an autopsy? *no*

What test confirmed diagnosis? *Sputum & x-ray*

(Signed) *J. H. Jones*

19

(Address) *St. Joseph's Hosp.*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Mount Vernon Church*

*5/9 1928*

UNDERTAKER

ADDRESS *916*

*Samuel Easton*

*Pa. av*

5-46  
333725

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

37 E 33725

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 16-22 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Almaia Johnson

## (a) RESIDENCE NO.

906 Mount St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

Black

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

12-5-22

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

5

5

2

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PLACE OF BIRTH (city or town)  
(State or country)

Md -

## 10 NAME OF FATHER

Emanuel Johnson

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Ida Pender

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md -

14

Informant  
(Address)

Records -

15

Filed

19

MAY 9 - 1928

P. M.

Registration

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 7 1928

17

I HEREBY CERTIFY, That I attended deceased from  
Apr. 27 1928, to May 7 1928.

that I last saw her alive on May 7 1928.

and that death occurred, on the date stated above, at 10:45 pm.

The CAUSE OF DEATH\* was as follows:

Miliary Tuberculosis 37

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY  
(Secondary)

Tuberculous meningitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted  
if not at place of death?

At home

Did an operation precede death? 1/0 Date of

Was there an autopsy? No

What test confirmed diagnosis?

Tubercle bacilli found in spinal fluid

(Signed)

J. J. Bennett M. D.

May 7, 1928 (Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Mt Auburn Cem

UNDERTAKER

Daniel E. Carter

DATE OF BURIAL

5/8-1928

ADDRESS

916 Be ne



E 33726 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33726

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 17 Glyndon Ave.

ST. 21-29 WARD

2. FULL NAME John R. Geoghegan Jr.

(a) RESIDENCE NO. 12 17 Glyndon Ave.

ST. 51 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs. mos.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)  
yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX male  
4 COLOR OR RACE white  
5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Kate Webster  
Geoghegan

DATE OF BIRTH (month, day, and year) July 28, 1858.

AGE Years Months Days  
69 9 9  
If LESS than  
1 day, hrs.  
or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Baltimore Md.

10 NAME OF FATHER John R. Geoghegan

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Kate Webster

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Baltimore Md.

14 Informant John R. Geoghegan  
(Address) 311 S. Stricker St.

15 Filed 1928 C. HAMMOND JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 19 28

17

I HEREBY CERTIFY, That I attended deceased from April 1, 19 28, to May 6, 19 28.

that I last saw him alive on May 6, 19 28

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH\* was as follows:

Aortic Insuff.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY Cardiac Asthenia  
(Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

(Address)

1126 W. Cross St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Louder Park

DATE OF BURIAL

5/9 1928

20 UNDERTAKER

Edmund Walter

ADDRESS

1000 Ashburton

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33727

## CERTIFICATE OF DEATH.

90 E 33727

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 W Fayette ST. 19-27 WARD)

## 2-FULL NAME

John B. Sherbert

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1600 W Fayette

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteSingle

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

June 6, 1892

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

35112

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Forester

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

A.A. Co. Md

## 10 NAME OF FATHER

E. L. Sherbert

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

A.A. Co. Md

## 12 MAIDEN NAME OF MOTHER

Mary E. Leroy

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

A.A. Co. Md

## 14

Informant (Address)

Mary E. Sherbert 10 N. Shubert St.

## 15

Filed

1928E. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

5/8/28 19

## 17

I HEREBY CERTIFY, That I attended deceased from

5/6/28, 19to 5/8/28, 19that I last saw him alive on 5/8/28, 19and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Autopsy

(Signed)

James P. Terry

M. D.

5/11/28 (Address) 712 W. ...

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

London ParkMay 10, 1928

## 20 UNDERTAKER

ADDRESS 1332George J. SmithHollins

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33728

## CERTIFICATE OF DEATH

90 E 33728  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *909 Binney* St. *11* Ward)2-FULL NAME *John W Dorn*(a) RESIDENCE NO. *909 Binney*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth *Life* yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*male white married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Annie Dorn*6 DATE OF BIRTH (month, day, and year) *May 5 1863*

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

*65 3*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Balt Sugar Co*

9 BIRTHPLACE (city or town)

(State or country) *Baltimore Md*10 NAME OF FATHER *George Dorn*11 BIRTHPLACE OF FATHER (City or town) *Germany*

(State or country)

12 MAIDEN NAME OF MOTHER *Annie*13 BIRTHPLACE OF MOTHER (City or town) *Germany*

(State or country)

14

Informant (Address) *Annie Dorn 909 Binney St*

15 Filed

*C. HAMPSON JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 8 1928*17 I HEREBY CERTIFY, That I attended deceased from *April 30 1928*, to *May 8 1928*, that I last saw him alive on *May 7 1928*, and that death occurred, on the date stated above, at *6:50 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cardiac hypertrophy - dilatation asphyxia**severe* (duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY

(Secondary)

(duration) *1* yrs. *1* mos. *1* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *W. M. Jones* M. D.*5/8 1928* (Address) *1014 S. Allwood Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

*St. Matthews May 10 1928*  
*William Beck 502 E North*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33729

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital

St. 24-35 Ward

## 2-FULL NAME

Joseph A. Roberts

## (a) RESIDENCE NO.

1442 Cooksie

St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred

(If non-resident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 Color or Race

W

## 5 Single, Married, Widowed, or Divorced, (write the word)

single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

56

5 6

01

Nov 6/1871

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Balto., Ms.

## 10 NAME OF FATHER Thomas A. Roberts

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

North Wales

## 12 MAIDEN NAME OF MOTHER Barbara Ettel

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto., Md.

## 14

Informant  
(Address)

Mrs. Wm Schmolt

2916 Fleetwood Ave

## 15

Filed

MAY 9 1928

HARRISON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) May 7/28

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said  
inquiry and that said deceased came to his death  
(Inquest, au-  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH was as follows:

Fractured Skull- Accidentally fell  
down Cellar steps at Residence  
of C.M. Watson, Hazelwood Ave,  
Raspburg

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

5/8/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place In the  
of death.....yrs.,.....mos.,.....ds. State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross, A. A. C.

Date of Burial 5/10 1928

## 20 UNDERTAKER

J. M. Cook

ADDRESS

502 E. North Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33730

## CERTIFICATE OF DEATH.

Registered No.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 633 S. Monford Ave. S. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) Residence No. 633 S. Monford Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds.

How long in U. S., if of foreign birth? 48 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

7-DATE OF BIRTH (month, day and year) 1859-3-19

7-AGE

69 yrs. 1 mos. 18 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town), (State or Country), Poland

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (city or town), (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Poland

14-

(Informant) Mrs. B. J. Jones  
(Address) 633 S. Monford Ave.

15-

Filed

C. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-7-28

17- I HEREBY CERTIFY That I attended deceased from April 20 28 to May 7 28 that I last saw him alive on May 7 1928

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Coronary Arteriosclerosis

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Jones, M. D.

(Address) 1000 N. ...

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Stephan J. Fialkowski

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33731

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. BALTIMORE CITY HOSPITAL ST. 113 WARD)

2-FULL NAME Ernest W. Egan

(a) RESIDENCE NO. 913 Mc Donough St.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Caucasian 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Mar. 6, 1894

AGE Years Months Days 34 4 1 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Washington (State or country) D. C.

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D. C.

12 MAIDEN NAME OF MOTHER William

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D. C.

14 Informant (Address) Deceased

15 Filed May 9, 1928 HAYDON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5/1928

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1928, to May 5, 1928 that I last saw him alive on May 5, 1928 and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumococcus meningitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Spinal

(Signed) C. Holmes Boyd M. D. , 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER Mrs. P. H. Elbert

May 9, 1928  
ADDRESS 1725 Ashland

*Margaret R Thompson*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33732  
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

9 E 33732  
REGISTERED NO.

City of BALTIMORE: (No. *1218 W. Lombard* St. *18-29* Ward)

2-FULL NAME *Margaret R Thompson*

(a) RESIDENCE NO. *1218 W Lombard* St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balti*  
(State or country)

10 NAME OF FATHER *W. J. Thompson*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Md*

12 MAIDEN NAME OF MOTHER *M. Schlin*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *N.Y.*

14 Informant *John Thompson*  
(Address) *1218 W Lombard St*

15 Filed..... 19 *28* *C. H. HANCOCK, JR., M. D.*  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

*5/7/28*, 19....., to *5/9/28*, 19.....,

that I last saw him alive on *5/9/28*, 19.....,

and that death occurred, on the date stated above, at *4:15 A.* m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) *Ischemic*  
(duration) *1* yrs. *1* mos. *1* ds.

(duration) *Ischemic* yrs. *1* mos. *1* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?..... Date of.....

Was there an autopsy? *No*

What test confirmed diagnosis? *Microscopic*

(Signed) *Wm. J. Jones*, M. D.

*5/9/28* (Address) *1218 W. Lombard*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

*Golden Park* *May 10 1928*  
*John White 1200 W Lombard*

33733

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Carlton

2-FULL NAME Walter S. Martin

(a) RESIDENCE NO. 120 S. Carlton

Length of residence in city or town where death occurred 1 yr. mos.

ST. 18-29 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE

Catherine D. Martin

7 DATE OF BIRTH (month, day, and year) Feb 8 1895

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

43

3

29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

B &amp; Q

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

George Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Ida Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

Mrs W D Martin

(Address)

120 S Carlton

15

Filed

19

HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7<sup>th</sup> 192817 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to May 7<sup>th</sup> 1928, that I last saw him alive on May 7<sup>th</sup> 1928, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Int. Nephritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine Analysis, Etc. (Signed) Chas. Burton, M. D.

(Address) 888 N Lombard St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Ardmore Park

DATE OF BURIAL

May 10 1928

20 UNDERTAKER

Wm. Fields 1700 N Lombard



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33734

## CERTIFICATE OF DEATH

E 33734

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1918 Patterson Place.

St. 8-16 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Strobel

(a) RESIDENCE NO. 1918 Patterson Place,

St. Ward

(Usual place of abode)

Lifetime

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Anthony C. Strobel

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min.

67

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

10 NAME OF FATHER

Patrick Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Ireland.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant

Family

(Address)

1918 Patterson Place.

15 Filed

9-1928

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 7th/ 1928

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

Cerebral Degeneration

Secondary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

8-9-1928

\*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery.

Date of Burial

May 10th. 1928.

20 UNDERTAKER

ADDRESS

Chas. P. Trause 118 N. Royal

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33735

## CERTIFICATE OF DEATH.

E 33735

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

I HEREBY CERTIFY, That I attended deceased from

May 3, 1928, to May 8, 1928,

that I last saw him alive on May 8, 1928,

and that death occurred, on the date stated above, at 10:25 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Appendicitis.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33736

## CERTIFICATE OF DEATH

50 E 33736

1-PLACE OF DEATH

Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No)

ST., 12-44 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. John L. Watson

(a) RESIDENCE NO.

Wagram, N.C.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

31 Years

Months

Days

If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Georgia

10 NAME OF FATHER

Daniel A. Watson (d)

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Ella M. Neil (d)

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.C.

14

Informant (Address)

Mr. John L. Watson Wagram, N.C.

15

Filed

C. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 9 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 3, 1928, to May 9, 1928,

that I last saw him live on May 9, 1928,

and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH\* was as follows:

Neoplastic Growth Large Bowel

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hemorrhage from Bowel

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Wagram, N.C.

Did an operation precede death?

Yes Date of 5-8-28

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Seroglutu

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Wagram, N.C.

DATE OF BURIAL

May 11, 1928

20 UNDERTAKER

J. O. Mitchell + Sons 1900 Eastern Pl.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33737

E 33737

## 1-PLACE OF DEATH

## CERTIFICATE OF DEATH

Merry Hospital

REGISTERED NO. 2758

City of BALTIMORE: (No.

## 2-FULL NAME

Herman Parkinson

St. 4-7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

31 Holland St.

St. Annapolis Md

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. 4 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced. (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan. / 1927

## 7 AGE

Years

Months

Days

1

4

IF LESS than  
1 day—hrs.  
or—min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

none

9 BIRTHPLACE (city or town)  
(State or country)

Annapolis Md

## 10 NAME OF FATHER

Herman L. Parkinson

11 BIRTHPLACE OF FATHER (City or town)  
(State or country)

Annapolis Md

## 12 MAIDEN NAME OF MOTHER

? ?

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

?

## 14

Informant  
(Address)

Hospital Record

## 15

1928

G. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 9 1928

19

## 17

I HEREBY CERTIFY, That I attended deceased from

May 5 1928

to May 9 1928

that I last saw him alive on

19

and that death occurred, on the date stated above, at

6:30 AM

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

Bronchopneumonia

(duration)

yrs.

mos.

3

da.

CONTRIBUTORY  
(Secondary)

Toxemia

(duration)

yrs.

mos.

2

da.

## 18 Where was disease contracted

If not at place of death:

Did an operation precede death?

Trajectory May 5 '28

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

J. Leyko

M. D.

19

(Address)

Merry Hospital

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## Date of Burial

Annapolis Md

May 9 1928

## 20 UNDERTAKER

Jas. S. Taylor &amp; Sons

## ADDRESS

Annapolis Md



33738

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33738

## —PLACE OF DEATH

CITY OF BALTIMORE: (No. 3537 Belair Ave

ST.

REGISTERED NO.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Wm. David Baynes

(a) RESIDENCE NO. 3537 Belair Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of Margaret E. Baynes

DATE OF BIRTH (month, day, and year) April 5-1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	3	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Co. Md

10 NAME OF FATHER James Baynes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Eliza Parlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

Informant Margaret E. Baynes

(Address) 3537 Belair Ave

Filed

1928

1

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8-1928

17

I HEREBY CERTIFY That I attended deceased from Jan 16 1925 to May 8 1928.  
 that I last saw him alive on May 7 1928  
 and that death occurred, on the date stated above, at 7:45 a m.

The CAUSE OF DEATH\* was as follows:

Exhaustion &amp; T. exaume

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clara Jones M. D.

18 1928 (Address) 4206 Hampden Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery

May 11 1928

20 UNDERTAKER

ADDRESS

George W. Jenkins

1737 E. Esplanade

33739 HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ E. 33739

33739 E

## CERTIFICATE OF DEATH.

91-00 68288 E

## 1. PLACE OF DEATH

CITY OF BALTIMORE:

No. 6307 Wallis ave

ST.

27-55 WARD

## 2. FULL NAME

Francis J. Willey

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

6307 Wallis ave

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed Thos J Willey

7 DATE OF BIRTH (month, day, and year)

Feb 8, 1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

3

— 29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

"

(c) Name of employer

"Phila Penna

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

"

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

"

"

14

Informant (Address)

Russell S. Willey 6307 Wallis ave Balto

15

Filed

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7/28 19

17

I HEREBY CERTIFY, That I attended deceased from May 4/27, 1928 to May 7, 1928 that I last saw her alive on May 7, 1928 and that death occurred, on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH\* was as follows

Atherosclerosis + Hypertension

(duration) 2 yrs. mos. ds. CONTRIBUTORY. Hypostatic Pneumonia (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed)

5/8/28 (Address) 5912 Park Heights

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmount Cemetery

May 10 1928

FUNDERAKER

ADDRESS

John B. Jones 1328 N. Calver

E 33740

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 909 Vine St. 18-16 Ward)2-FULL NAME Ellen Adams

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 909 Vine St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race Negro 5 Single, Married, Widowed, or Divorced, (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 63 Months \_\_\_\_\_ Days \_\_\_\_\_ IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address)

15 Filed 1928 2433 HAMPSON RRH Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Probably Cancer of the Uterus (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

(Signed) Reginald J. Hill M. D. (Coroner)Address 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

19

THE MORRIS

33741

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital - 110*)2-FULL NAME *Albert Gregory*(a) RESIDENCE NO. *802 Mulberry St.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. *159-003 E 33741*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 Color or Race

*Negro*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER *Helena Gregory*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## PARENTS

## 14

Informant (Address)

*University Hospital*

## 15

## FILED

## 2431

## 19

## C. HAMPSON JONES, M. D.

## Registrar

## 20 UNDERTAKER

*CHARLES H. ROBERTS*

Address

1928

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 5 1928*17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Probably Pyloic obstruction*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed)

(duration)

yrs. mos. ds.

(Coroner)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds.

In the

State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

UNIVERSITY OF MARYLAND

## 20 UNDERTAKER

*CHARLES H. ROBERTS*

Address

1928

MAY 8 1928



33742

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

✓  
E 33742

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals ST. 9-5 WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John White

(a) RESIDENCE NO. 1123 E. Pratt st.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. n mos.

ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of or WIFE of Ida Jones

DATE OF BIRTH (month, day, and year) 1885

AGE Years Months Days If LESS than 1 day... hrs. or... min.  
43

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant (Address) Hospital Records

15 Filed 1928 19 C. HAMPTON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1928

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1928 to May 6, 1928, that I last saw him alive on May 6, 1928, and that death occurred, on the date stated above, at 3:30 a. m.  
The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis Clinical & lab.

(Signed) W. M. D. M. D. 5-6-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Sacred Heart

DATE OF BURIAL

20 UNDERTAKER J. J. Leahy team

ADDRESS 5-9 1928  
1318 Light

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33743

E 33743

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 600 S. Montford Ave St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME REGINA B. STANKIEWICZ,

(a) RESIDENCE NO. 600 S. Montford Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22-1926.

7 AGE Years Months Days IF LESS than 1 day hrs. or min.. I 10 17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.

10 NAME OF FATHER Bronislaus Stankiewicz,

11 BIRTHPLACE OF FATHER (City or town) Poland, (State or country)

12 MAIDEN NAME OF MOTHER Anna Kogut,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) MD.

14 Informant Mrs. Anna Stankiewicz, (Mother) (Address) 600 S. Montford Ave

15 Filed 1928 C. HAMISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1928

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1928, to May 9, 1928, that I last saw her alive on May 9, 1928, and that death occurred, on the date stated above, at 11:40 A. M.

The CAUSE OF DEATH\* was as follows:

Malignant Measles Apr. - Apr. 22  
Bronchopneumonia Apr. 22 - 29  
Meningitis - Apr. 29 - May 9  
(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. S. D. Lippert, M. D.

19 (Address) 432 S. Patterson St. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

St. Stanislaus Cem

May 10 1928

20 UNDERTAKER

ADDRESS

Michael A. Sadowski

705 S. Ann St.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33744

E 33744

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital 11-17* ST. *11-17* WARD)

### 2-FULL NAME

(a) RESIDENCE NO. *Livingston Mills, Md* ST. *11-17* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. / mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male*

*White*

*married*

If married, widowed, or divorced HUSBAND of (or) WIFE of

*Lena Myers*

DATE OF BIRTH (month, day, and year)

*1869*

AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*59*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Unknown*

14

Informant (Address)

*Mrs Lena Myers*

15

Filed

*1928* *G HAMPSON JONES, M. D.*

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*5/7/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*4/18/28*, 19, to *5/9/28*, 19

that I last saw him alive on *5/7/28*, 19

and that death occurred, on the date stated above, at *2:25 P. m*

The CAUSE OF DEATH\* was as follows:

*cerebral thrombosis*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*H Lawrence Fahoney*

M. D.

19

(Address) *St Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Westminster. Meadow Brook* *5/12/28*

20 UNDERTAKER

*HB Burkard & Son*

ADDRESS

*Westminster Md*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33745

## CERTIFICATE OF DEATH.

31

E 33745

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 N. Gilman ST.,

WARD)

## 2. FULL NAME

Alma M. Nixon

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

433 N. Gilman ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 23 mos. 23 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7<sup>th</sup> 192817 I HEREBY CERTIFY, That I attended deceased from May 1<sup>st</sup> 1928 to May 7<sup>th</sup> 1928,  
that I last saw her alive on May 6<sup>th</sup> 1928,  
and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH\* was as follows:

Acute PhthisisAtt 4 mo (duration) yrs. 4 mos. ds.CONTRIBUTORY  
(Secondary)Inf. pneumonia  
(duration) yrs. 8 mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

58, 1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

M. AuburnMay 10, 1928

20 UNDERTAKER

ADDRESS

J. L. Brown & Co.10 E. N. Montgomery



33746

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33746

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals ST. 11-B WARD)2-FULL NAME Thomas Brown(a) RESIDENCE NO. 1030 Carlton st.  
(Usual place of abode)Length of residence in city or town where death occurred Unknown mos.ST. 11-B WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) SingleIf married, widowed, or divorced  
HUSBAND of  
or WIFE ofDATE OF BIRTH (month, day, and year) 1910AGE 18 Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Coal yard(c) Name of employer UnknownBIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Ben Brown11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Hannah Barrett13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Hospital Records  
(Address)15 Filed C. HAMPSON JONES, M. D. 19 1928 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 192817 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1928 to May 8, 1928that I last saw him alive on May 8, 1928and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

Tuberculous peritonitisPulmonary tuberculosis(duration) Unknown yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical & lab.(Signed) Henry C. Smith, M. D.5-8-1928 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Mt. AuburnMay 10, 1928

20 UNDERTAKER

ADDRESS

Sam H. Chase & Son1450 Mosh

E 33747

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33747

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4215 Connecticut Ave ST., WARD 11)

## 2. FULL NAME

Wilhelmina Schrepper(a) RESIDENCE No. 4215 Connecticut Ave WARD 11  
(Usual place of abode)Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of John G Schrepper (or) WIFE of6 DATE OF BIRTH (month, day, and year) Jan 8 18657 AGE Years 63 Months 3 Days 29 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany  
(State or country)10 NAME OF FATHER Thos. Link11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Anna M. Schrepper13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant John J. Schrepper  
(Address) 4215 Conn. Ave15 1928 C. HAMPSON JONES, M. D., Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 192817 I HEREBY CERTIFY, That I attended deceased from Feb 21 1928 to May 7 1928, that I last saw her alive on May 7 1928and that death occurred, on the date stated above, at 10:50 P.M.

The CAUSE OF DEATH\* was as follows:

Diabetic Gangrene (both feet)CONTRIBUTORY (duration) Diabetes yrs. mos. ds. 7  
(Secondary) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No By Dr. J. H. JonesWhat test confirmed diagnosis? Pathological(Signed) James H. Jones M.D.  
Address 1729 N. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Park Cem5/10/28

20 UNDERTAKER

ADDRESS

Engel & Feltz

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33748

## CERTIFICATE OF DEATH

129 E 33748

## —PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 Roslyn Ave. ST. 15-61 WARD)

—FULL NAME Grace Miller Hickman

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2603 Roslyn Ave. ST.,

## WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 3 mos. 10 ds.

How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE female white 5 Single, Married, Widowed, or Divorced, (write the word) married

6 married, widowed, or divorced HUSBAND of J. Walter Hickman (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Jan 28 1879

8 AGE Years 48 Months 3 Days 10 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Oliver J. Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Sarah Armiger

13 BIRTHPLACE OF MOTHER (city or town) Laurel (State or country)

Informant Mrs. Walter Hickman (Address) 2603 Roslyn Ave.

1928 CHAMBERSON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1928

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to May 8, 1928, that I last saw her alive on May 8, 1928, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH was as follows:

Cerebral hemorrhage -

CONTRIBUTORY (duration) yrs. mos. ds. Artistic Schizophrenia - Initial (Secondary) Psychosis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard H. Warner, M. D.

May 8 1928 (Address) 2604 Garrison Ave.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Woodlawn Cemetery

May 10 1928

20 UNDERTAKER

## ADDRESS

Chas. G. Black 742 W. North Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33749

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 24 Ward 34)

## 2-FULL NAME

(a) RESIDENCE NO. 739 E. Fort. Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)  
Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 14/ 1871

7 AGE

Years

56

Months

9

Days

24

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer Bucks Glass Co;

9 BIRTHPLACE (city or town)

(State or country)

Delaware

10 NAME OF FATHER

James M Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Mary A. Knoler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Delaware

14

Informant  
(Address)

Mary A. McKenzie

127 Calvert Ave.

15

Filed

C. H. HANCOCK

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 192817 I HEREBY CERTIFY that I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said  
(Inquest, au-  
topsy or inquiry.)  
and that said deceased came to his death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY  
(Secondary)May 7/28 (duration) 1 mos. 1 ds.  
128 (Signed) J. C. Stader (Coroner) M. D.  
(Address) 143 N. 1 St. Bay\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Seaford Delaware

5/10 1928

20 UNDERTAKER

ADDRESS

Wm Cook

502 E. North



E 33750

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33750

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 S. Charles St. ST. 90-43-31 WARD)

2—FULL NAME Susanna E. Drury.

(a) RESIDENCE NO. 1430 S. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX female. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced, (write the word) Widowed.

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of William A. Drury.

DATE OF BIRTH (month, day, and year) April, 11, 1849

AGE 79. Years Months Days 27 If LESS than 1 day, hrs. or min. 29.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home.

BIRTHPLACE (city or town). Md. (State or country)

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town). Dont know. (State or country)

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town). Dont know. (State or country)

14 Informant Albert Drury, Son).

(Address) 1430 S. Charles St.

15 Filed 1928-19 Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1928

17 I HEREBY CERTIFY That I attended deceased from May 8, 1928, to May 8, 1928.

that I last saw her alive on May 7, 1928.

and that death occurred, on the date stated above, at 15:30 A.M.

The CAUSE OF DEATH\* was as follows:

Senile myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7 ds.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) J. H. Harrison, M. D.

1928 (Address) 1430 S. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

May 11, 1928

20 UNDERTAKER

ADDRESS

A. Howard Evans 28 E. Fort Ave.

E 33751

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33751

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 So Gilmor St.

ST. 19-28 WARD)

2-FULL NAME Barbara Louise Hamson

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 230 So. Gilmor St.

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Widowed

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Late John H. Hamson

DATE OF BIRTH (month, day, and year) Mar. 3rd. 1840

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

88

2

4

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER John Stettler

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Charles C. Hamson

230 So. Gilmor St

15

Filed

C. HAMMOND JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7<sup>th</sup> 1928

17

I HEREBY CERTIFY, That I attended deceased from May 1<sup>st</sup> 1928, to May 7, 1928,

that I last saw her alive on May 7, 1928

and that death occurred, on the date stated above, at 1:45<sup>PM</sup> m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis,  
Mitral Stenosis  
Bronchial Asthma

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

5/9, 1928 (Address) 2000 Halliwell St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

5/10/28

20 UNDERTAKER

ADDRESS

Harry H. Witke 1531 W Lombard St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33752

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH  
City of BALTIMORE: (No. St. Joseph Hospital St., 9-17 Ward)

2-FULL NAME Jacob Billingslea

(a) RESIDENCE NO. 1011-19 Locust St. Phila., Pa. Pa. Pa.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Alice Billingslea

6 DATE OF BIRTH (month, day, and year) Feb 11/1854

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
<u>74</u>	<u>3</u>	<u>28</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.; Md.

(State or country)

10 NAME OF FATHER Basil Billingslea

11 BIRTHPLACE OF FATHER (city or town) Balto., Co., Md.

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Billingslea

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co., Md.

(State or country)

14 Informant John Frank Billingslea (son)

(Address) Forrest Hill, Md.

15 Filed 1928

R. J. JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:  
Probably Chr. Nephritis

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ds. over

(Signed) J. S. Hester (Coroner) M. D.

5/9/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Chapel Cem. Date of Burial May 11/28

20 UNDERTAKER Thompson & Sons

ADDRESS Baltimore, Md.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33753

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3167 Green* ST., *4-25* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *3167 Green*

(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. *8* mos. *10* ds.

REGISTERED NO.

E 33753

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*If married, widowed, or divorced HUSBAND of *Wife*

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*54**11**10**23*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Photographer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*George Petri*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Augusta Fisher*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14 Informant (Address)

*Minnie R. Petri*  
*3167 Green St.*

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*5/8/28*

17

HEREBY CERTIFY, that I attended deceased from *April 23, 1928* to *May 8, 1928*, that I last saw him alive on *May 8, 1928*, and that death occurred, on the date stated above, at *1143* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

CONTRIBUTORS (secondary)

*Myocardial Regeneration*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Hubert Dorn* M. D.  
*1707 North St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

*Linden Park Cem*

20 UNDERTAKER

*Joseph Syber*

DATE OF BURIAL

*May 19, 1928*

ADDRESS

*1600 St. North Ave*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33754

## CERTIFICATE OF DEATH.

89 ✓  
8-45  
REGISTERED NO.

E 33754

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1670 Darley Ave

St.,

Ward

## 2-FULL NAME

Kate V. Pickering

## (a) RESIDENCE NO.

1670 Darley Ave

St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 Color or Race

5 Single, Married, Widowed,  
or Divorced. (write the word)

Female

White

Widow

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Late John T Pickering

## 6 DATE OF BIRTH (month, day, and year)

May 8/1860

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

00

0

0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....none(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

## 9 BIRTHPLACE (city or town)

(State or country)

Carroll Co., Md.

## 10 NAME OF FATHER

David Bloom

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Carroll Co., Md.

## 12 MAIDEN NAME OF MOTHER Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

## 14

Informant  
(Address)

S. Leonberger

1670 Darley Ave

## 15 Filed....., 19

1928 H. Harrison Jones, M.D.  
Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 8/28

## 17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-topsy or inquiry.) and that said deceased came to her death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cardiac Valvular Insufficiency

(Angina Pectoris)

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(Signed)

(duration) ..... yrs. .... mos. .... ds.

(Coroner) M. D.

(Address)

5/9/28

508 E. North Ave

State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)At place In the  
of death..... yrs. .... mos. .... ds. State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial  
REMOVALNew Windsor, Md. May 10 1928  
20 UNDERTAKER  
William Beck 512 E. North Ave

33755

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33755

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Balto. Eye and Ear Hospital**1214 Eutaw Place*

CITY OF BALTIMORE: NO.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Arletta Ward*(a) RESIDENCE. NO. *161 Virginia Ave. - West* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F.*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Feb. 14 1918*

7 AGE

*10* Years*2* Months*25* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Student*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Bowens**Calvert Co. Md.*

10 NAME OF FATHER

*Edward J. Ward*

11 BIRTHPLACE OF FATHER (city or town)

*Bowens*

(State or country)

*Calvert Co. Md.*

12 MAIDEN NAME OF MOTHER

*Elsie Maity*

13 BIRTHPLACE OF MOTHER (city or town)

*Germany*

(State or country)

14

Informant (Address)

*Arletta Ward**161 Virginia Ave. - West*

15

Filed

MAY 10 1928 J. DON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9 1928*

17

HEREBY CERTIFY, That I attended deceased from

*May 4 1928, to May 9 1928.*that I last saw her alive on *May 9 1928.*and that death occurred, on the date stated above, at *6:10 p. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebro-Spinal Meningitis.*(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

*Acute Otitis Media.*(duration) yrs. mos. *13* ds.

18 Where was disease contracted

if not at place of death? *161 Virginia Ave.*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical.*

(Signed)

*N. F. Graff* M. D.

, 19 (Address)

*1214 Eutaw Place.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Worrell**May 11 1928*

20 UNDERTAKER

*William Cochran 502 E. North*

33756

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33756

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

439 N. East Ave. ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Henry Keirsey

(Residence in Baltimore: No.

439 N. East Ave.

St.; yrs.; mos.; ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male White

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH.

Aug 22, 1927

7-AGE,

8 yrs. 8 mos. 17 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,

(State or Country),

Balto.

PARENTS.

10-NAME OF FATHER,

Bernard S. Keirsey

11-BIRTHPLACE OF FATHER

(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Doris E. Keirsey

13-BIRTHPLACE OF MOTHER

(State or Country),

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Bernard S. Keirsey

(Address)

439 N. East Ave.

15-

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 9, 1928

17- I HEREBY CERTIFY, That I attended deceased from

3/25/28 191, to 5/9/28 191

that I saw him alive on 4/27/28 191

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Charles H. Keirsey

9/9/28 (Address) 439 N. East Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Barraine Ave.

DATE OF BURIAL,

May 12, 1928

20-UNDERTAKER

John W. Keirsey

ADDRESS

200 N. East Ave.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33758

## CERTIFICATE OF DEATH

100-801  
E 33758

1-PLACE OF DEATH

Suai Hosp

CITY OF BALTIMORE: (No.

ST. 10-14 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna Rosenfeld

(a) RESIDENCE NO.

805 Aisquith St

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

yrs. 17 mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, year)

May 10 1916

AGE

Years

Months

Days

If LESS than 1 day, hrs or min

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

David Rosenfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Rosen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

David Rosenfeld 805 Aisquith St

15

Filed

19

C. HAMMOND JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/9 1928

17

I HEREBY CERTIFY, That I attended deceased from

5-7 1928 to 5-9 1928

that I last saw her alive on

5-9 1928

and that death occurred, on the date stated above, at

4:30 P M

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

5/9 1928 (Address)

J. H. Shovel Suai Hosp

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Reuben Rosenfeld

J. H. Shovel 1439 E. 1st St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

33759

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hospitals (135) ST. 25-31 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Robert Harris

### (a) RESIDENCE NO.

25 Patapsco st. Mt. Vernon

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of or WIFE of

Unknown

DATE OF BIRTH (month, day, and year) 1889

AGE Years Months Days If LESS than 1 day, hrs. or min. 39

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(h) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

BIRTHPLACE (city or town) (State or country)

South Carolina

10 NAME OF FATHER Edd Harris,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Catherine Nobles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14

Informant (Address)

Hospital Records

15

Filed 1928 19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 19 28

17

I HEREBY CERTIFY, That I attended deceased from April 30, 19 28, to May 7, 19 28, that I last saw him alive on May 7, 19 28,

and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) L. E. M. M. M., M. D.

5-7-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Auburn

DATE OF BURIAL

May 10 19 28

20 UNDERTAKER

Sam'l. T. M. M.

ADDRESS 78

W. D. M.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33760

## CERTIFICATE OF DEATH.

89 E 33760

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 N. Montgomery ST., 12 WARD)2. FULL NAME Dora Henkel(a) RESIDENCE NO. 827 N. Montgomery ST., 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos.How long in U. S., if of foreign birth? 4 yrs. mos.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) WidowedIf married, widowed, or divorced HUSBAND of (or) WIFE of Frederick HenkelDATE OF BIRTH (month, day, and year) Aug 11 1882AGE Years 45 Months 8 Days 26 If LESS than 1 day. hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Charles Franz11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Catherine13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14

Informant Mr. Fred. Henkel (Address) 827 N. Montgomery

15

Filed AY 10 1928Registrar W. H. Jones

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1928

17

I HEREBY CERTIFY, That I attended deceased from April 10, 19 28, to May 6, 19 28.that I last saw him alive on May 6, 19 28.and that death occurred, on the date stated above, at 12 10 noon m.

The CAUSE OF DEATH\* was as follows:

Cardio-Vascular Dis (Angina Pectoris)(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? —(Signed) Thos. E. Brown M. D., 19 (Address) 125 S. B. Way

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Baltimore

DATE OF BURIAL

20 UNDERTAKER Philip HenwigADDRESS 2016

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33761

## CERTIFICATE OF DEATH.

90 E 33761

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 511 McMechen ST. 14-20 WARD)

## 2-FULL NAME

Charlotte Francis Goodman

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

511 McMechenST., 14-20 WARDLength of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Colwidowed

If married, widowed, or divorced, HUSBAND of (or) WIFE of

John Thomas Goodman.

DATE OF BIRTH (month, day, and year)

Dec 14-1858

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

694 24

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Baltimore County

10 NAME OF FATHER

Emanuel Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore County

12 MAIDEN NAME OF MOTHER

Louise Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore County

14

Informant (Address)

Caroline Goodman  
511 McMechen St.

15

Filed

1028 HAMMON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 7 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 29, 1928, to May 7, 1928, that I last saw him alive on May 7, 1928,and that death occurred, on the date stated above, at 30 PM.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed)

Paul H. Brown, M. D.

(Address)

58. 1928 1837 Pennsylvania Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ricestertown Md.May 9 1928

20 UNDERTAKER

ADDRESS

Thomas B. Kelson1303  
Presidents



33762

## HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 33762

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Balto City Hospitals*  
 CITY OF BALTIMORE: (No. *Balto Md.* ST. *8-17* WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

2-FULL NAME *William Harbaugh*

(a) RESIDENCE No. *1309 N. Bond St.* ST. \_\_\_\_\_ WARD \_\_\_\_\_  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred *11* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed,  
 or Divorced, (write the word) *married*

If married, widowed or divorced  
 HUSBAND of *Fannie Harbaugh*  
 or) WIFE of

DATE OF BIRTH (month, day, and year) *Sept. 16-1888*

AGE Years Months Days *39 7 22* If LESS than  
 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or  
 particular kind of work *Mechanic of*

(h) General nature of industry,  
 business, or establishment in  
 which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
 (State or country) *Pennsylvania*

10 NAME OF FATHER *Jacob Harbaugh*

11 BIRTHPLACE OF FATHER (city or town)  
 (State or country) *Pennsylvania*

12 MAIDEN NAME OF MOTHER *Viola Eyler*

13 BIRTHPLACE OF MOTHER (city or town)  
 (State or country) *Pennsylvania*

14 Informant *Balto City Hospital*  
 (Address) *Balto Md.*

15 Filed *1923* Registrar *R. H. C.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-9-1928*

17 I HEREBY CERTIFY, That I attended deceased from  
*2-3-*, 19*28*, to *5-9-*, 19*28*  
 that I last saw him alive on *5-8-*, 19*28*  
 and that death occurred, on the date stated above, at *12:45 A.* m.

18 CAUSE OF DEATH was as follows:

*Cardiac Failure*

(duration) yrs. mos. ds.  
 CONTRIBUTORY *Psychosis with Cerebro*  
 (Secondary) *Spinal Syphilis*  
 (duration) yrs. mos. ds.

19 Where was disease contracted  
 if not at place of death? *Unknown*

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *Physical & Serological*  
 (Signed) *Harry J. G. Smith, M.D.*  
 . 19 (Address) *Baltimore City Hospitals*

\*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR  
 REMOVAL *North Lawn Cemetery* DATE OF BURIAL *May 12 1928*

UNDERTAKER *George L. Schwab & Son Ltd. Inc.* ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33763

## CERTIFICATE OF DEATH.

46 E 33763

### 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 2709 Elinor Ave. St. 15-61 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Belle Young Thompson

Residence in Baltimore: No. 2709 Elinor Ave. St. 49 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

DATE OF BIRTH, Dec 30, 1878 (Month) (Day) (Year)

AGE, 49 yrs., 4 mos., 8 ds. IF LESS than 1 day, .... hrs. or .... min.?

OCCUPATION: (a) Trade, profession, or particular kind of work, Home duties (b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE, (State or Country), Balt Md

PARENTS. 10-NAME OF FATHER, Russell Young 11-BIRTHPLACE OF FATHER, Ba 12-MAIDEN NAME OF MOTHER, Mary W McKay 13-BIRTHPLACE OF MOTHER, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel A. Thompson (Address) 2709 Elinor Ave.

15-

Filed 10-10-1928 C. HAMMOND JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8, 1928 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1-28 1928, to May 8 1928, that I saw her alive on May 8 1928, and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Ovary (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Fracture (Duration) .... yrs. .... mos. .... ds.

(Signed) Edward J. Warner M. D. May 8, 1928 (Address) 2607 Garrison

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Truist Ridge DATE OF BURIAL, May 10, 1928

20-UNDERTAKER, Substitute Undertaker ADDRESS Truist Ridge

E 33764

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3003 Frederick Ave ST. 10-70 WARD)

2-FULL NAME George Beck

(a) RESIDENCE No. 3003 Frederick Ave ST. 10-70 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 25 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) May 14/1926

AGE

Years

1

Months

11

Days

25

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

William R Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Naomi S Drenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

William R Beck  
3001 Frederick Ave

15

Filed

May 10 1928

HARRISON JONES, M. D.  
R. H. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1928, to May 9, 1928,

that I last saw him alive on May 9, 1928,

and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH\* was as follows:

Scarlet Fever  
suppurative cerebral meningitis  
rhinocerebral

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Yes

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Culture

(Signed)

Robert H. Jones M. D.

(Address)

3167 Melrose Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOV.

St. Christ Cemetery

DATE OF BURIAL

May 10 1928

20 UNDERTAKER

Harry H. Amos 4204 Ridgewood Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33765

## CERTIFICATE OF DEATH.

\* 129 E 33765

## 1-PLACE OF DEATH

TY OF BALTIMORE: (No. *Sinia Wash* ST. *7-12* WARD)2-FULL NAME *Frank Morgan*(a) RESIDENCE NO. *Bushwood Rd.* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

*19* ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *January*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*68*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*md*10 NAME OF FATHER *John Morgan*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*md*12 MAIDEN NAME OF MOTHER *Just known*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)*Frank Morgan**416 N. 1st St.*

15

Filed

19

*HARRISON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6/9* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from  
*4/20/* 19 *28* to *5/9* 19 *28*,  
that I last saw him alive on *5/9* 19 *28*and that death occurred, on the date stated above, at *4:55 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cardio - Vascular Renal Disease*

(duration)

*7* yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)*Cardiac failure, marked*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *Yes* Date of *5/4/28*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed)

*M. Sherry*

M. D.

19

(Address)

*Local Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Bushwood Rd*

20 UNDERTAKER

*Joseph Ahrens*

DATE OF BURIAL

*5/10/28*

ADDRESS

*221 Buoy*





E 33767

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33767

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 24 Baton Ave.

City of BALTIMORE: (No. 24 Baton Ave.

St. 20-70 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Kidwell

(a) Residence No. 24 Baton Ave.

(Usual place of abode)

St. Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS.

SEX Male 4-COLOR OR RACE Black 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Kidwell

b-DATE OF BIRTH (month, day and year) Oct. 9, 1860

c-AGE 67 yrs. 7 mos. 29 ds. If LESS than 1 day, hrs. or min.?

## OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Driver (b) General nature of industry, business, or establishment in which employed (or employer) for Balto Lumber Co. (c) Name of employer

9-BIRTHPLACE (city or town) Prince George Co. Md. (State or Country)

10-NAME OF FATHER John H. Kidwell

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country)

12-MAIDEN NAME OF MOTHER Barlett Brooks

13-BIRTHPLACE OF MOTHER (city or town) Md. (State or Country)

14- (Informant) Eliza Kidwell (Address) 24 Baton Ave.

15- Filed 10 1928 C. HANCOCK JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May - 8 - 1928

17- I HEREBY CERTIFY, That I attended deceased from March 3<sup>rd</sup> 1928, to April 8<sup>th</sup> 1928, that I last saw him alive on April 8<sup>th</sup> 1928, and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH\* was as follows:

Parenchymatous Nephritis

CONTRIBUTORY (Secondary)

18-Where was disease contracted at place of death If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Russell Fargo M. D.

, 19 (Address) 2937 N. Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Harrison Town Private Cem. Catonsville DATE OF BURIAL May 12, 1928

20-UNDERTAKER G. W. Dill ADDRESS 9109 Fredk. Ave.

33768

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001E 33768

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Welcome

### 2. FULL NAME

Frank Roach

### (a) RESIDENCE No.

654 W. Lee

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds.

ST.

WARD

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

### REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

#### SEX

male

#### 4 COLOR OR RACE

Col

#### 5 Single, Married, Widowed, or Divorced, (write the word)

married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Lillian Roach

#### 6 DATE OF BIRTH (month, day, and year)

1880

#### 7 AGE

Years 43

Months —

Days —

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stevens

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

### 9 BIRTHPLACE (city or town) (State or country)

Elizabeth City N. Carolina

### 10 NAME OF FATHER

Irony Roach

### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Elizabeth City N. Carolina

### 12 MAIDEN NAME OF MOTHER

Ann

### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Elizabeth City N. Carolina

### 14

Informant (Address)

Lillian Roach 654 W. Lee St.

### 15

Filed 1928

C. H. JONES, M. D.

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

5/9/1928

#### 17

I HEREBY CERTIFY, That I attended deceased from 5/1, 1928, to 5/9, 1928.

that I last saw him alive on 5/8, 1928.

and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH\* was as follows:

acute lobal pneumonia

(duration) — yrs. — mos. 9 ds.

### CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

### 18 Where was disease contracted if not at place of death?

@ work

Did an operation precede death? w Date of

Was there an autopsy? w

What test confirmed diagnosis?

(Signed) Dan J. Jones, M. D. 5/9, 1928 (Address) 142 W. Lee St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

Elizabeth City N.C.

5/10-28

### 20 UNDERTAKER

Samuel Easton Pa ar

13687  
E 33769

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

+ 100-E 33769

## 1-PLACE OF DEATH

## REGISTERED NO.

CITY OF BALTIMORE: (No. 7-4 ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barry Himmelhaber(a) RESIDENCE NO. Eastern Ave - Rd - ST. 8 WARD Taylor Ave -

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

10 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) 12-18-27

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

4

21

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Md -

10 NAME OF FATHER Fredrich11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md -

12 MAIDEN NAME OF MOTHER Katherine Barmen13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md -

14

Informant  
(Address)

Records -

15

Filed

1928

6

HAMPSON

JONES

M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 29, 1928 to May 9, 1928,  
that I last saw him alive on May 9, 1928,  
and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH\* was as follows:

Meningitis, pneumococcus(duration) yrs. mos. 3 ds.CONTRIBUTORY  
(Secondary)Pneumonia, Broncho(duration) yrs. mos. 14 ds.18 Where was disease contracted  
if not at place of death?HomeDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

Exam. Spinal fluid

(Signed)

J. F. Barmen

M. D.

(Address)

John F. Barmen

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALInt. Carmel Cemetery

DATE OF BURIAL

5/11 1928

20 UNDERTAKER

John G. Connelly

ADDRESS

Croxy



33770

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33770

## CERTIFICATE OF DEATH

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 3609 Fernwood Ave ST. 129-37)

FULL NAME Jacob H. Ermer

a) RESIDENCE NO. 3609 Fernwood Ave ST.

(Usual place of abode)

Place of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 4 COLOR OR RACE

Male White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

Married, widowed, or divorced

HUSBAND of (or) WIFE of

Bertha M. Ermer

DATE OF BIRTH (month, day, and year) Feb 20 1889

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39

1

19

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

Oil Treater

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

Standard Oil Co.

BIRTHPLACE (city or town) (State or country)

Balto, Md.

10 NAME OF FATHER

John Ermer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Caroline Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant

(Address)

Bertha M. Ermer  
3609 Fernwood Ave

Filed

MAY 10 1928

HAMPSON JONES

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9-1928

17

I HEREBY CERTIFY, That I attended deceased from 10.23.27, 19, to 5.9.28, 19

that I last saw him alive on 5.8.28, 19

and that death occurred, on the date stated above, at 3:50 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic Intestinal Neoplasia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Philip B. Fowler, M. D.  
5.9.28 (Address) 1432 William St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

First Evangelical Cemetery

DATE OF BURIAL

May 12, 28

ADDRESS

1737 E. Eager St

20 UNDERTAKER

George W. Zinkler

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33771

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *7-12* WARD)

## 2-FULL NAME

*Francis Roberts*

## (a) RESIDENCE NO.

*2423 Arden Ave*

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

*Oct 2, 1926*

AGE

Years

Months

Days

If LESS than  
1 day... hrs.  
or min.*1**7**8*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Baltimore  
Maryland*

10 NAME OF FATHER

*Frank Roberts*

11 BIRTHPLACE OF FATHER (city or town)

*Balt.*

(State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Helen Dale*

13 BIRTHPLACE OF MOTHER (city or town)

*Balt.*

(State or country)

*Md.*

14

Informant  
(Address)*Hospital Record*

15

Filed

19

*HANSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10, 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*May 4, 1928, to May 10, 1928,*that I last saw him alive on *May 10, 1928,*and that death occurred, on the date stated above, at *1:45 a. m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria - Tracheitis &**Parapharyngeal*(duration) yrs. mos. *10* ds.CONTRIBUTORY *late toxic myocarditis*  
(Secondary)(duration) yrs. mos. *7* ds.18 Where was disease contracted  
if not at place of death?*At home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*Bacteriological*(Signed) *Dr. J. P. Levin* M. D.5-10, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Holy Redeemer Cemetery**May 11, 1928*

20 UNDERTAKER

ADDRESS

*Henry Stoen, Inc. 1201 E. Eager St.*

33772

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33772

## CERTIFICATE OF DEATH

1-PLACE OF DEATH *Union Memorial Hospital* X 100-001  
CITY OF BALTIMORE: (No. *33rd & Calvert* ST. *12-49* WARD)2-FULL NAME *Mrs. Elizabeth Jones*(a) RESIDENCE NO. *Delto Pa.*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST. WARD

(If non-resident give city or town and State)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

EX 4 COLOR OR RACE *Male white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced HUSBAND of (or) WIFE of *Daniel Jones*DATE OF BIRTH (month, day, and year) *May 30 1858*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Penn.*10 NAME OF FATHER *John E. Williams*11 BIRTHPLACE OF FATHER (city or town) (State or country) *England*12 MAIDEN NAME OF MOTHER *Jane Davis*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *England*Informant (Address) *Union Hosp. Records 33rd & Calvert Ave.*

15

Filed 1928

19

HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10 1928*

17

HEREBY CERTIFY, That I attended deceased from *Mar. 23, 1928* to *May 10, 1928*, that I last saw her alive on *May 10, 1928*, and that death occurred, on the date stated above, at *1:30 P. M.*

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia*

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical exam*  
(Signed) *J. J. Seragutty* M. D.19 (Address) *Union Memorial Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Delto, Pa.**Mo. Pa.*

33773

HEALTH DEPARTMENT—CITY OF BALTIMORE

33773

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Little Sister of the Poor 10-14* Ward)

2-FULL NAME

*Edwin Whitson*

(a) RESIDENCE NO.

*Preston + Valley*

St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred *67* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

*M*

4 Color or Race

*W*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1861*

7 AGE

Years

Months

Days

*67*

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*H. I. A*

10 NAME OF FATHER

*Daniel Whitson*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

*Lyncha Spedden*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

*Little Sister of the Poor Preston + Valley St*

15 Filed

*1928*

*C. HAMPSON JONES, M. D.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 7*, 19*28*, to *May 9*, 19*28*, that I last saw him alive on *May 8*, 19*28*, and that death occurred, on the date stated above, at *100 a* m.

The CAUSE OF DEATH\* was as follows:

*Chronic subacute disease*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. *3* mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Dr. Bernard Weiss*, M. D.

9. 1928 (Address) *914 E. Biddle St*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Friendship Cm. Fallston Md May 11, 1928*

20 UNDERTAKER

*Rita Windefield 914 Green St*



33774

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33774

## CERTIFICATE OF DEATH

1-PLACE OF DEATH *Union Memorial Hospital*  
CITY OF BALTIMORE: (No. *33rd and Calvert ST.*) WARD *19*2-FULL NAME *Mr. William B. Johnson*(a) RESIDENCE NO. *Ocala Fla.* ST. *4th* WARD *19*  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Mrs. William B. Johnson*DATE OF BIRTH (month, day, and year) *Aug 7 1852*

AGE

Years

Months

Days

*76**10**3*If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Merchant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*North Carolina*10 NAME OF FATHER *William Johnson*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*N.C.*12 MAIDEN NAME OF MOTHER *Sarah Johnson*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*N.C.*14 Informant *S. Mc Gready*  
(Address) *Ocala Fla.*15 Filed *0 1928* *G. HAMPSON JONES, M. D.*  
*R. R. H.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10, 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*May 6, 1928, to May 10, 1928.*that I last saw him alive on *May 6, 1928*  
and that death occurred, on the date stated above, at *11<sup>00</sup> A. M.*

The CAUSE OF DEATH\* was as follows:

*Myocardial failure*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical examination*(Signed) *Frank Kuler Morris*, M. D.5/10, 1928 (Address) *Union Mem. Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Volusia Co. Fla.*  
*Harry Perkins S. C.**May 10 1928*  
*Ocala Fla.*

33775

HEALTH DEPARTMENT—CITY OF BALTIMORE E 33775

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Balto City Hosp*  
 CITY OF BALTIMORE: (No. *Balto md* ST. *10-37* WARD)  
 2. FULL NAME *Mary Howell*  
 (a) RESIDENCE NO. *Unknown* ST. *Unknown* WARD

REGISTERED NO. *38*  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX *female* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

If married, widowed, or divorced HUSBAND of or WIFE of

DATE OF BIRTH (month, day, and year) *1879*

AGE Years Months Days If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer) *Domestic*  
 (c) Name of employer

BIRTHPLACE (city or town) (State or country) *N. Carolina*

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14 Informant (Address) *Balto City Hosp*  
*13 Balto md*

15 Filed *1928* *C. HAMPSON JONES, M. D.* Registrar *2425 RCH*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-7-28*

17 I HEREBY CERTIFY, That I attended deceased from *3-28*, 19*28*, to *5-7*, 19*28*, that I last saw her alive on *5-7*, 19*28*, and that death occurred, on the date stated above, at *7:30* m.

The CAUSE OF DEATH\* was as follows:

*General Paralysis of Insane*  
 (duration) yrs. mos. ds.  
 CONTRIBUTORY *Bacterial Infection*  
 (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical & Serological*  
 (Signed) *Harry F. Jones, M.D.*  
 (Address) *Baltimore City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL  
 UNIVERSITY OF MARYLAND.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*CHAMBERLAIN & SONS*

*MAY 10 1928*

33776

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE, (NO)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15

Filed

19

Registrar

ST. 16-76 WARD

WARD

(If non-resident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
5-1, 1928 to 5-1, 1928

that I last saw him alive on 5-1, 1928

And that death occurred, on the date stated above, at 9.00 P. m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. H. Chapman M. D.

1928 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

JOHN S HOPKINS HOSPITAL  
20 UNDERTAKER

ADDRESS

Commissioner Health.

MAY 10 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33777

E 33777

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2065 Hoodberry Ave. ST., 13-57 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 2065 Hoodberry Ave. ST., 13 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 40 yrs. mos.(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 11-1883

AGE Years 74 Months 4 Days 28 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15

Filed

C. HAMPTON JONES, M. D.  
Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1928

17 I HEREBY CERTIFY, That I attended deceased from 1924, to May 9, 1928, that I last saw him alive on May 9, 1928, and that death occurred, on the date stated above, at 2:10 A. m. The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. W. E. H. M. D.  
1928 (Address) 7020 N. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS



# HEALTH DEPARTMENT—CITY OF BALTIMORE

33778

## CERTIFICATE OF DEATH.

31 E 33778

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balts. City Hosp.* ST. *29* WARD)

### 2. FULL NAME

*Vera Bartel*

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### (a) RESIDENCE NO.

*1347 Sylvania Ave.*

(Usual place of abode)

Length of residence in city or town where death occurred *9* yrs. *9* mos. *9* ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

EX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*7*

*W*

*Married*

If married, widowed, or divorced *HUSBAND* of or) WIFE of *Joseph Bartel*

DATE OF BIRTH (month, day, and year)

*1901*

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*27 yrs*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Joseph Smith*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Lithuania*

12 MAIDEN NAME OF MOTHER

*Mrs. Rice*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Lithuania*

14

Informant (Address)

*Hospital Recd. Balts. City Hospital*

15

Filed

*0 1928*

*C. HAMMON JONES, M. D. Registrar*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 9 1928*

17

I HEREBY CERTIFY, That I attended deceased from *March 13, 1928*, to *May 9, 1928*.

that I last saw him alive on *May 9, 1928* and that death occurred, on the date stated above, at *810 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

*Clinical & Lab*

(Signed)

*L. E. Madden, M. D.*

4-10-1928 (Address)

*Balts. City Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Scranton Pa.*

DATE OF BURIAL

*May 11 1928*

ADDRESS

*423 S. Pratt*

UNDERTAKER

*John Grethausen*

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 33779

33779

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1326 N. Chester

ST. 8-17 WARD)

2-FULL NAME Catherine Rebecca McAfee

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1326 N. Chester

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Job W. McAfee

DATE OF BIRTH (month, day, and year) Sept. 14, 1846

AGE Years Months Days If LESS than 1 day, hrs. or min.

81 7 24

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER Michael B. Cline

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ohio

12 MAIDEN NAME OF MOTHER Catherine Beery

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant Miss Alma McAfee (Address) 1326 N. Chester St.

15

C. HAMPSON JONES, M. D.

File

0 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 19 28

17 I HEREBY CERTIFY, That I attended deceased from 5:00 p.m. to May 7, 19 28, that I last saw him alive on May 6, 19 28, and that death occurred, on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH\* was as follows:

Cancer Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? m Date of

Was there an autopsy? m

What test confirmed diagnosis? all

(Signed) M. T. Riley, M. D.

May 8, 19 28 (Address) 1639 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

London Park Cemetery

May 10 19 28

2 UNDERTAKER

ADDRESS

1005 West

Baltimore St.

33780

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33780

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 W. Baltimore

ST. 18-29 WARD

## 2-FULL NAME

Mollie Mansfield

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1001 W. Baltimore

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Female

White

Widowed

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Samuel Mansfield

DATE OF BIRTH (month, day, and year) Dec. 31, 1846

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

81

5

10

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md.

10 NAME OF FATHER George Plack

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER Katharine Krass

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant Mr. James W. Bowers  
(Address) 1001 W. Baltimore St.

15

C. HAMPSON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr 24, 1926, to May 9, 1928.

that I last saw her alive on May 7, 1928.

and that death occurred, on the date stated above, at 9:15 A. M.

The CAUSE OF DEATH\* was as follows:

Hyperstatic Pneumonia.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY Arterio-sclerosis  
(Secondary)

(duration) 4 yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard L. French, M. D.

1908 (Address) 707 Edmonson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Loudon Park Cemetery

DATE OF BURIAL

Mar. 11 1928

20 UNDERTAKER

Joseph H. Cook

ADDRESS

1005 West  
Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33781

## CERTIFICATE OF DEATH.

E 33781

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Balt. Gen. Hosp. 16-69* ST. *16-69* WARD)2. FULL NAME *William Burton*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2735 Harlem Ave*

(Usual place of abode)

ST. *16-69* WARDLength of residence in city or town where death occurred *Life* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
<i>Male</i>	<i>White</i>	<i>Widowed</i>

If married, widowed, or divorced  
HUSBAND of *Mary M. Burton*  
(or) WIFE of

DATE OF BIRTH (month, day, and year) *July 8, 1864*

AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	<i>63</i>	<i>10</i>	<i>1</i>	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Railroad Work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Retired*BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*10 NAME OF FATHER *William T. Burton*11 BIRTHPLACE OF FATHER (city or town) *Unknown*  
(State or country)12 MAIDEN NAME OF MOTHER *Margaret Bottle*13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)4 Informant *Mrs. Margaret Chase*  
(Address) *2735 Harlem Ave.*5 Filed *1928* 19 *28*Registrar *ARM*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from *April 14, 1928* to *May 9, 1928*,  
that I last saw him alive on *May 9, 1928*,  
and that death occurred, on the date stated above, at *11:45 A. m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Prostate Gland.*

(duration) *unknown* yrs. mos. ds.  
CONTRIBUTORY (Secondary) *Myocarditis with failure*  
(duration) *18* yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?Did an operation precede death? *Yes* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Examination of autopsy*  
(Signed) *Paul Schenker* M. D.5/9, 1928 (Address) *West Balt. Gen. Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Oaklawn Cemetery*20 UNDERTAKER *W. H. Cook*

## DATE OF BURIAL

*May 12, 1928*

## ADDRESS

*1003 West Baltimore*



33782

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 33782

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1241 Sharpe St ST. 73-31 WARD)

2-FULL NAME Edward J. Shea

Residence in Baltimore: No. 1241 Sharpe St St.: Life yrs., 0 mos., 0 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

DATE OF BIRTH, March 3, 1878  
(Month) (Day) (Year)

AGE, 50 yrs., 2 mos., 5 ds. If LESS than 1 day, ... hrs. or ... min.?

OCCUPATION:  
(a) Trade, profession, or particular kind of work. Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer). Iron Foundry

BIRTHPLACE, (State or Country), Baltimore City

10-NAME OF FATHER, Nicholas Shea

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget O'Brien

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Edward Shea

(Address) 1241 S. Sharp St

15-

Filed 1928 C. HAMPSON JONES, M. D. Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8, 1928  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10, 1926, to May 8, 1928, that I saw him alive on May 7, 1928, and that death occurred, on the date stated above, at 3:35 A.M.

The CAUSE OF DEATH\* was as follows:  
Pulmonary Tuberculosis

(Duration) ? yrs., 0 mos., 0 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) 2 yrs., 0 mos., 0 ds.

(Signed) H. Lawrence Wheeler, M. D.  
May 8, 1928 (Address) Harvard St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Cross Church DATE OF BURIAL, May 11, 1928

20-UNDERTAKER Margaret J. Fyfe ADDRESS 1422 Light St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

33783

## CERTIFICATE OF DEATH.

33783

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. BonSecours HospitalST. 28-64 WARD 64

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

William Harry Legg

## (a) RESIDENCE No.

4012 Hillside Road

(Usual place of abode)

ST. 28-64 WARD 64

Length of residence in city or town where death occurred

26 yrs. — mos. — ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)MaleWhiteMarriedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofMrs. Evelyn Legg

DATE OF BIRTH (month, day, and year)

May 8, 1889

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.39----

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Car Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

B. & O. R. R.BIRTHPLACE (city or town)  
(State or country)Kent Co. Md.

10 NAME OF FATHER

William H. Legg

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Kent Co. Md.

12 MAIDEN NAME OF MOTHER

Billy Russum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Kent Co. Md.14 Informant  
(Address)Mrs. Evelyn Legg  
4012 Hillside Road15 Filed 10-19-28C. HAMPSON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 19 28, to May 8, 19 28,that I last saw him alive on May 8, 19 28,and that death occurred, on the date stated above, at 10 55 P m.

The CAUSE OF DEATH\* was as follows:

Typhoid Fever(duration) yrs. mos. 21 ds.CONTRIBUTORY  
(Secondary)Same

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical & Laboratory

(Signed)

George O. Eaton, M. D.

19 (Address)

Bon Secours Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Landon ParkGeo W Little

33784

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33784

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Lennox

## 2-FULL NAME

Frank P. Harten

(a) RESIDENCE No. 707 Lennox

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs -- mos. -- ds.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Elizabeth Ora Stone

DATE OF BIRTH (month, day, and year) July 9, 1853

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	10	1	

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work...

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Delaware

10 NAME OF FATHER

Unobtainable

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

Frank J. Harten

225 E. University Parkway

15

Filed

U 1928

C. HAMPTON JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/1928

17

I HEREBY CERTIFY That I attended deceased from May 1, 1928, to May 10, 1928,

that I last saw him alive on May 10, 1928,

and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH\* was as follows:

*Coronary Atherosclerosis  
Myocardial Infarction*

(duration) yrs. mos. 9 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas J. White, M.D.

, 19 (Address) 532.7 22nd St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cemetery

5/12 1928

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calver St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33785

90 E 33785

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

HAMPSON

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Sept 1927 to May 8 1928 that I last saw him alive on May 8 1928 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH\* was as follows:

Cardiac Disturbance

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



E 33786

Sorell  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33786

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 17th Callov Ave WARD 10

## 2-FULL NAME Susan Sorell

(a) RESIDENCE NO. 1934 17th Callov Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1928, to Feb. 21, 1928, that I last saw him alive on Feb. 21, 1928, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH\* was as follows:

Adipose glands - Fatty liver

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVIAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33787

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *621 W. Conway* Ward) *22-30*

2-FULL NAME.....

*Algie Branch*  
*621 W. Conway*

Registered No. *E 33787*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. ....

(Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. *0* mos. *0* ds.

How long in U. S. if of foreign birth? *0* yrs. *0* mos. *0* ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX, *male*

COLOR OR RACE, *Colored*

5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-If married, widowed, or divorced HUSBAND of (or) WIFE of

7-DATE OF BIRTH (month, day and year) *04 15 1908*

8-AGE, *19* yrs. *6* mos. *24* ds.

If LESS than 1 day, ... hrs. or ... min.?

9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

10-BIRTHPLACE (city or town, State or Country), *Va*

10-NAME OF FATHER *Henry Branch*

11-BIRTHPLACE OF FATHER (State or Country), *W. Alex Md*

12-MAIDEN NAME OF MOTHER *Alveta Beck*

13-BIRTHPLACE OF MOTHER (city or town, State or Country), *Md*

14-

(Informant) *Henry Branch*

(Address) *621 W. Conway St*

15-

Filed *11 1928*

*HAMPSON JONES, M. D.*

Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) *5-9-28*

17-I HEREBY CERTIFY, That I attended deceased from *April 18 28* to *May 9 28*

that I last saw him alive on *9 May 19 28*

and that death occurred, on the date stated above, at *6:40 P.M.*

The CAUSE OF DEATH\* was as follows:

*Acute hepatitis*

CONTRIBUTORY (Secondary) *Acute Endocarditis*

(Duration) *21* mos. *7* ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *W. C. Good*

(Signed) *W. C. Good*, M. D.

, 19 *28* (Address) *501 W. Hamburg St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL *Mt Calvary Cem* DATE OF BURIAL, *5/11/28*

20-UNDERTAKER *Walter B. Spriggs* ADDRESS *139 W. Hamburg*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33788

## CERTIFICATE OF DEATH.

E 33788

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

Offington &amp; Chilham Roads

Mt. Washington.

St.

Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Sidney R. Greenwald

## (a) RESIDENCE NO.

Offington &amp; Chilham Rds. St.

Ward

(Usual place of abode)

Length of residence in city or town where death occurred

Lifetime

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Madeline F. Greenwald

6 DATE OF BIRTH (month, day, and year)

Jany. 6th. 1897.

## 7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

31

4

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Broker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore.

(State or country)

Md.

## 10 NAME OF FATHER

Julius Greenwald

## 11 BIRTHPLACE OF FATHER (city or town)

Balto.

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Rebecca Rose

## 13 BIRTHPLACE OF MOTHER (city or town)

Richmond.

(State or country)

Va.

## 14

Informant Mrs. Madeline Greenwald

(Address) Offington &amp; Chilham Rds.

## 15

Filed 1928

19

C. H. HANSEN

Registrar

90 27-54

St.

Ward

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/ 1928

## 17

I HEREBY CERTIFY That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

hereon and from the evidence obtained by said

Inquest, autopsy or inquiry, and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Stenosis

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(Signed)

(duration)

yrs.

mos.

ds.

(Coroner)

M. D.

, 19

(Address)

14376 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Hebrew Burial Society

5/11/ 1928

## 20 UNDERTAKER

David Soudan

ADDRESS

115-20 W. Mt. Royal Ave.

33789

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 100-001 E 33789)

ST. 40 WARD

2. FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from

May 4, 1928, to May 9, 1928,

that I last saw him alive on May 9, 1928,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Bacterial broncho pneumonia

Myocardial insufficiency

(duration) yrs. mos. 7 ds.

Myocardial insufficiency

(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

Clinical diagnosis - Physical

(Signed) M. D.

19 (Address) A. H. T. T. T.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS



# HEALTH DEPARTMENT—CITY OF BALTIMORE

33790

33790

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 1811 Madison Ave St. 14-20 Ward)

### 2-FULL NAME

Walter Hill

### (a) RESIDENCE NO.

1811 Madison Ave

Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 11 ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME, instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race W.C. 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Elen Hill

6 DATE OF BIRTH (month, day, and year) May 28 1877

7 AGE Years 50 Months 11 Days 1 IF LESS than 1 day.....hrs. or.....min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer For Isaac Emerson

9 BIRTHPLACE (city or town) Bath Me (State or country)

10 NAME OF FATHER Walter

11 BIRTHPLACE OF FATHER (city or town) Me (State or country)

12 MAIDEN NAME OF MOTHER Walter

13 BIRTHPLACE OF MOTHER (city or town) Me (State or country)

14 Informant (Address) Elen Hill  
1811 Madison Ave

15 Filed 1928 19 11 Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9<sup>th</sup> 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.

### The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
(Apoplexy)  
(duration) 1 yrs. 11 mos. 11 ds.

### CONTRIBUTORY

(Secondary) Febrile (duration) 1 yrs. 11 mos. 11 ds. (Address) Coroner

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

### 19 PLACE OF BURIAL CREMATION OR REMOVAL

St. Auburn Cem May 11 28

19 UNDERTAKER Sumner Handy ADDRESS Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33791

33791

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hosp 7-53*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *0* mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*7*

4 COLOR OR RACE

*W.*

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

*Oct. 2 1918*

AGE

Years

*9*

Months

*7*

Days

*7*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

*Norfolk Va.*

10 NAME OF FATHER

*John Lewis*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Norfolk Va.*

12 MAIDEN NAME OF MOTHER

*Russell*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Norfolk Va.*

14

Informant (Address)

*Principal of the Home - Miss F. E. Beasley*

Filed

*11 1928**H. J. Jones*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 9 1928*

17

I HEREBY CERTIFY, That I attended deceased from *April 20*, 19*28*, to *May 9*, 19*28*.that I last saw her alive on *May 9*, 19*28*.and that death occurred, on the date stated above, at *12:05 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia - lobes - left*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Pancreatic*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. J. Jernigan*, M. D., 19 (Address) *Union Memorial Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

BURYAL

*Woods Cemetery**May 11 1928*

20 UNDERTAKER

ADDRESS

*John B. Spence 1325 N. Carroll St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33792

E 33792

## 1. PLACE OF DEATH

TY OF BALTIMORE: (NO.

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 4-14, 1928, to 5-10, 1928,

that I last saw him alive on 5-10, 1928,

and that death occurred, on the date stated above, at 2-40<sup>00</sup> m.

The CAUSE OF DEATH\* was as follows:

C.A. of Stomach

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-19-28

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lawrence Fahmy, M.D.

, 19 (Address) St. Joseph's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

3793

HEALTH DEPARTMENT—CITY OF BALTIMORE E 33793

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Square Hospital*  
CITY OF BALTIMORE: (No. *Culham & Fayette* ST. *18-76* WARD)

REGISTERED NO. *16-002*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James Gilbert Pearce*

(a) RESIDENCE NO. *10 19 W. Fayette*  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. *22* mos. ds. *5*  
ST. *18-76* WARD *16-002*  
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

If married, widowed, or divorced HUSBAND of (or) WIFE of *child*

DATE OF BIRTH (month, day, and year) *June 20, 1926*

AGE Years *1* Months *10 mo* Days *20*  
If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, md.*  
(State or country)

10 NAME OF FATHER *Reese Wilbur Burton*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore, md.*  
(State or country)

12 MAIDEN NAME OF MOTHER *Mildred Pearce*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore, md.*  
(State or country)

14 Informant *Mother Mildred Pearce Brand*  
(Address) *719 W. Fayette St.*

Filed *11 1928* C. H. HANCOCK, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10 1928*

17 I HEREBY CERTIFY, That I attended deceased from *May 3*, 1928, to *May 10*, 1928, that I last saw him alive on *May 9*, 1928, and that death occurred, on the date stated above, at *5:30 A.* m.

The CAUSE OF DEATH\* was as follows:  
*Dysentery (Miss-Russell)*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Positive stool cultures*

(Signed) *Elizabeth B. Sherman*, M. D.

, 19 (Address) *Franklin Sq. Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Mount Olivet*

UNDERTAKER *George J. Smith*

DATE OF BURIAL

*May 12 1928*

ADDRESS *1532 Hollins St*



E 33794

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33794

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

BALTIMORE CITY HOSPITAL

ST. \_\_\_\_\_

WARD \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Alexander Hillburg

## (a) RESIDENCE NO.

337 Dolphin

(Usual place of abode)

ST. \_\_\_\_\_

WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred \_\_\_\_\_

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Colored

Single

(If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

45 Years

Months

Days

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work

Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

West Indies

## 10 NAME OF FATHER

Isadore

11 BIRTHPLACE OF FATHER (city or town) (State or country)

West Indies

## 12 MAIDEN NAME OF MOTHER

Jannita Savanor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

West Indies

Informant (Address)

Record

Filed

19

H. JONES, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-9 1928

17

I HEREBY CERTIFY, That I attended deceased from 4-25, 1928, to 5-9, 1928,

that I last saw him alive on 5-9, 1928, and that death occurred, on the date stated above, at 5:50 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) C. Holmes Burch, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart

20 UNDERTAKER

J. J. Trahey Sons

DATE OF BURIAL

5/11 1928

ADDRESS

1318 Light St

E 33795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 33795

I. PLACE OF DEATH

CITY OF BALTIMORE: (No

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

11 1928

C. HAMPSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 4-4-1928 to 5-10-1928 that I last saw him alive on 10 May 1928 and that death occurred, on the date stated above, at 4 a. m. The CAUSE OF DEATH\* was as follows:

myocarditis

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 33796 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 100-001 E 33796

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Balto City Hopt.*CITY OF BALTIMORE: (No. *Balto Ind*)ST. *13-54* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Charles Adreon*(a) RESIDENCE No. *2219 Arden Ave*

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred *life* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*If married, widowed, or divorced HUSBAND of *Wife Adreon* or) WIFE ofDATE OF BIRTH (month, day, and year) *Aug 30 1888*AGE *39* Years Months Days *8 10* If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Joseph Adreon*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Emma Smith*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*4 Informant *Balto City Hopt.* (Address)5 Filed *1928* 19 *C. H. JONES, M.D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5 10 19 28*

17

I HEREBY CERTIFY, That I attended deceased from *5-8*, 19 *28*, to *5-10*, 19 *28*, that I last saw him alive on *5-10*, 19 *28*

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*Terminal Broncho Pneumonia  
Acute Alcoholic Delirium*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Alcoholic Psychosis*  
(duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Microscopic findings*  
(Signed) *Wm. H. H. Smith* M.D.  
(Address) *Baltimore City Hopt.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Lorraine Park*

DATE OF BURIAL

20 UNDERTAKER *Chenoweth & Son*ADDRESS *8610 Chrysalis*

34 E 33797 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

57 E 33797

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 18-76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Carrie Forrer

(a) RESIDENCE No.

1015 Edmondson

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

11 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Widow

If married, widowed, or divorced

HUSBAND of

or WIFE of

Frank B Forrer

DATE OF BIRTH (month, day, and year)

Oct 19 1868

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59

6

21

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

La

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

Records

15

Filed

1928

19

JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr 24 1928 to May 10 1928

that I last saw her alive on May 10 1928

and that death occurred, on the date stated above, at 8 a - m.

The CAUSE OF DEATH\* was as follows:

Pyonephrosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

Diabetes mellitus

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. J. Jones, M. D.

5 10 1928 (Address) Johns Hopkins

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Woodlawn

May 13, 28

Chenoweth &amp; Chestnut



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33798

## CERTIFICATE OF DEATH

E 33798

## PLACE OF DEATH

CITY OF BALTIMORE; (No. 1410 E Biddle ST., 10-13)

FULL NAME

Sophia A Hammond

a) RESIDENCE NO.

1410 E. Biddle ST.,

(Usual place of abode)

Place of residence in city or town where death occurred

50

yrs.

mos.

ds.

How long in U. S., if foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

W

5 Single, Married, Widowed,  
or Divorced, (write the word)

Widowed

married, widowed, or divorced  
HUSBAND or  
(or) WIFE of

William B. Hammond

DATE OF BIRTH (month, day, and year)

Aug 6, 1842

AGE

Years

85

Months

9

Days

3

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work

Housewife

b) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)Cecil Co  
Md

10 NAME OF FATHER

John Aldridge

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Elizabeth Cottier

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

Informant

Ella A. Wilkinson

(Address)

1410 E. Biddle St

File

1928

19

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 9, 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 2, 1928, to May 9, 1928

that I last saw him alive on May 9, 1928

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

CONTRIBUTORY  
(Secondary)Broncho-pneumonia  
(duration) 2 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

19 (Address) Medical Arts Bldg.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Lorraine

May 11, 1928

20 UNDERTAKER

ADDRESS

H. M. Cook

302 E. North Ave

E 33799

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33799

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 E. Church ST., 22-32 WARD)

## 2. FULL NAME

Baby Girl Seeman

## (a) RESIDENCE NO.

113 E. Church ST., 22-32 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. 10

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

FemaleWhiteSingleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofSingle

## DATE OF BIRTH (month, day, and year)

May 1, 1928

## AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.10

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore, Md

## 10 NAME OF FATHER

Melvin Seeman

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Richmond Va

## 12 MAIDEN NAME OF MOTHER

Eva Betz

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

## 14

Informant

(Address)

Neerhu

## 15

Filed

MAY 11 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10 19 28

17

I HEREBY CERTIFY, That I attended deceased from  
May 1, 19 28 to May 10, 19 28  
that I last saw her alive on May 10, 19 28,  
and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH\* was as follows:

Congenital atelectasia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

M. Alexander Hovey, M. D.

, 19

(Address) 2516 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Western CemeteryMay 11 1928John F. Denny755 Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 33800

197-E 33800

1-PLACE OF DEATH

City of BALTIMORE: (No. 14<sup>th</sup> & 10<sup>th</sup> St. St. 26-37 Ward)

2-FULL NAME

Francis Burlew

(a) RESIDENCE NO.

14 & 10 St.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Don't know

AGE

Years 20

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Paper bag factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Hamburg Pa

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Don't know

14

Informant (Address)

Mr. Laura H. German 14 & 10 St.

15

Filed

11 1928

R. M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 5 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said Inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Gun shot wound to the chest

CONTRIBUTORY (Secondary)

May 3/28 14310 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Mount Carmel Cem May 28

20 UNDERTAKER

ADDRESS

John Ulrich 218 Orleans

33801

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

E 33801

1-PLACE OF DEATH

City of BALTIMORE: (No. 4140-5th St. 76-37 Ward)

2-FULL NAME

(a) RESIDENCE NO. 4140-5th St. 76-37 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

M

W

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Christopher Hurner

6 DATE OF BIRTH (month, day, and year) Aug 12/1892

7 AGE

Years 35

Months 8

Days 27

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER Joseph Lgmes

11 BIRTHPLACE OF FATHER (city or town) Balto

12 MAIDEN NAME OF MOTHER Kathrine Mc

13 BIRTHPLACE OF MOTHER (city or town) Balto

14

Informant (Address) Kathrine Lgmes

15

Filed 11/19/28

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1928

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death of the day stated above.

The CAUSE OF DEATH was as follows:

Carcinoma of Breast

(Duration) 3 mos. (Secondary) Exhaustion

(Signed) W. E. Davis (Coroner) M. D.

(Address) 143 N. 1st St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where disease contracted, if not at place of death!

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross Date of Burial May 12

20 UNDERTAKER

Wendell D. Appel ADDRESS Eden May



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33802  
1-PLACE OF DEATHCITY OF BALTIMORE: (No. *Sydenham Hospital 25-72* WARD)2-FULL NAME *Catherine Roth*(a) RESIDENCE NO. *Herkimer St. 613* *Ward* *Mottell Park*  
(Usual place of abode)Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) *May 22, 1925*AGE Years Months Days If LESS than 1 day. hrs. or min.  
*2 11 19*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Baltimore*  
(State or country)10 NAME OF FATHER *Harry Roth*11 BIRTHPLACE OF FATHER (city or town) *Balt.*  
(State or country) *Md.*12 MAIDEN NAME OF MOTHER *Maria Creamer*13 BIRTHPLACE OF MOTHER (city or town) *Balt.*  
(State or country) *Md.*14 Informant (Address) *Harry Roth*  
*Herkimer St. 613* *Ward* *Mottell Park*15 Filed *11 1928*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 33802

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11, 1928*17 I HEREBY CERTIFY, That I attended deceased from *May 11, 1928* to *May 11, 1928*, that I last saw her alive on *May 11, 1928*, and that death occurred, on the date stated above, at *735* a. m.

The CAUSE OF DEATH\* was as follows:

*Retropharyngeal Abscess*  
*(Respiratory obstruction)*(duration) yrs. mos. ds. *21*

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis *Clinical*(Signed) *Dr. J. L. Levin* M. D.5-11, 1928 (Address) *Sydenham Hospital*  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

*Mr. Oliver*  
*Mr. Mrs. J. W. Zupfel & Son* *5014 Zupfel*

33803

# HEALTH DEPARTMENT—CITY OF BALTIMORE E 33803

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2520 McCulloch* ST., *13-59* WARD)

### 2-FULL NAME

(a) RESIDENCE NO. *2520 McCulloch* ST., *13-59* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *♂*

4 COLOR OR RACE *col*

5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

If married, widowed, or divorced HUSBAND of (or) WIFE of *Not stated*

DATE OF BIRTH (month, day, and year) *Mar 1 1870*

AGE

Years *58*

Months *2*

Days *8*

If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer) *-*

(c) Name of employer *-*

9 BIRTHPLACE (city or town) (State or country) *Md*

10 NAME OF FATHER *Henry Caesar*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*

12 MAIDEN NAME OF MOTHER *Mary Murdoch*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14

Informant (Address) *William Caesar (Bro.) 207 Dolphin St.*

15

Filed *1928*

16

*C. HAMPSON JONES, M. D.* Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9 1928*

17

HEREBY CERTIFY, That I attended deceased from *Apr. 30*, 1928, to *May 9*, 1928.

that I last saw her alive on *May 9*, 1928.

and that death occurred, on the date stated above, at *2:00 P. m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach*  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *-*

Did an operation precede death? *no*

Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank E. Wagner, M. D.*

(Address) *1126 Edmondson*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Auburn Cemetery*

*May 12 1928*

20 UNDERTAKER

*John M. Johnson*

*Address 1234 E. 11th St.*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Hax Alley ST. 3-4 WARD)

### 2-FULL NAME

Shueas Hughes

(a) RESIDENCE NO. 1526 Hax Alley ST. 3-4 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Hughes

7 DATE OF BIRTH (month, day, and year) 1891

AGE

Years 37

Months

Days

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Informant (Address) Emily Hampton  
1527 Pratt St

15

Filed 1928

19

20

Registrar R. H. Jones

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1928

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1928, to May 10, 1928, that I last saw him alive on May 8, 1928, and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Tuberculosis - Acute Cardiac

(duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Servatius, M. D.

19 (Address) 38 S. Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

1515 Maryland St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33805

CERTIFICATE OF DEATH.

183 E 33805

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital, 6-9 Ward)

2-FULL NAME James Cullison

(a) RESIDENCE NO. 2002 Lincoln Court St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred 1 yr. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 Color or Race col 5 Single, Married, Widowed, or Divorced, (write the word) single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 29 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

10 NAME OF FATHER Henry Cullison

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co., Md.

12 MAIDEN NAME OF MOTHER Bessie Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) King & Queen Co., Va

14 Informant Ella Bennett (Address) 1621 McElderry St

15 1928 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8/28 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bilateral Pneumonia, Pistol Shot wound abdominal viscera & rt Pleura Probably self inflicted & accidental (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. M. D. (Coroner)

5/10/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER Address



33806

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33806

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 845 Woodward ST., WARD)

## 2-FULL NAME

Frederick Joseph Beck, Jr.

## (a) RESIDENCE NO.

845 Woodward

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

## DATE OF BIRTH (month, day, and year)

March 21, 1911

## AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

17

2

17

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## PARENTS

## 10 NAME OF FATHER Frederick Joseph Beck

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

## 12 MAIDEN NAME OF MOTHER Georgia M. Keenan

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

## 14

Informant (Address)

Mrs. H. A. Keenan 1509 Holbrook Street

## 15

Filed

19

C. HARRISON JONES, M. D.

Register

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) May 8 1928

## 17

I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1928, to May 8, 1928.

that I last saw him alive on May 18, 1928.

and that death occurred, on the date stated above, at 11.10 P. M.

The CAUSE OF DEATH\* was as follows:

Mild Stenosis and Acute Nephritis

(duration) yrs. 4 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. M. H. Hoag, M. D.

(Address) 729 Washington Blvd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cem.

## DATE OF BURIAL

May 12, 1928

## 20 UNDERTAKER

## ADDRESS

100 West Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE 33807

33807

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 242 N. Fulton Ave. ST. 11 WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

2-FULL NAME Jean Victor Stoffel

(a) RESIDENCE NO. 242 N. Fulton Ave. ST. 11 WARD  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced  
 HUSBAND of Mary Drevess Stoffel  
 (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 23, 1849

AGE Years Months Days If LESS than 1 day, hrs. or min.  
 78 5 16

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Organist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Lorraine  
(State or country) France

10 NAME OF FATHER Jean Stoffel

11 BIRTHPLACE OF FATHER (city or town) France  
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Thibault

13 BIRTHPLACE OF MOTHER (city or town) France  
(State or country)14 Informant Mrs. Mary Stoffel  
(Address) 242 N. Fulton Ave.

15 Filed 1928 G. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th. 19 28

17 I HEREBY CERTIFY, That I attended deceased from April 29th. 19 27. to May 9th. 19 28.  
 that I last saw him alive on May 9th. 19 28.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis 2 Yrs.  
 Chronic Nephritis 1 Yr.

(duration) yrs. mos. ds.

CONTRIBUTORY Cerebral Hemorrhage  
(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E. H. Revell M. D.

19 (Address) 242 N. Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer

May 12 19 28

20 UNDERTAKER

ADDRESS

1003 West Baltimore St

33808

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5229 Clark, Se

ST.

WARD

2-FULL NAME

Barth C. Hennelly

(a) RESIDENCE NO.

5229 Clark Ave.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

48

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

a If married, widowed, or divorced, HUSBAND of (or) WIFE of

John Hennelly

DATE OF BIRTH (month, day, and year)

January 1862

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

yrs

4

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va

10 NAME OF FATHER

Wm Kiddell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Mr. Richard Hennelly 5229 Clark Ave.

15

Filed

1928

C. HANCOCK JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-10

1928

17

I HEREBY CERTIFY, That I attended deceased from

for 4 or 5 yrs.

that I last saw him alive on

5-9

and that death occurred, on the date stated above, at

1409

The CAUSE OF DEATH\* was as follows:

Cancer of stomach and intestines

(duration)

3 yrs?

mos

ds.

CONTRIBUTORY (Secondary)

Asthma

(duration)

15

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

Yes

Date of

Aug 1927

Was there an autopsy?

No

What test confirmed diagnosis?

Microscopic

(Signed)

Henry Russell

M. D.

5-10-1928 (Address)

3902 Grosvenor St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Peters Cemetery

UNDERTAKER

Joseph J. Cook

DATE OF BURIAL

May 12 1928

ADDRESS

1505 West Baltimore St.

33809

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33809

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Barclay

ST. 12-14 WARD)

## 2-FULL NAME

Catherine G. Green

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1709 Barclay

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

60

yrs.

--

mos.

--

ds.

How long in U. S. if of foreign birth?

--

yrs.

--

mos.

--

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

William P. Green

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs or min

82

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

Nathaniel Leighthousen

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Unobtainable

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Mrs. Catherine M. Sheubrooke 4500 York Road

15

Filed

1-10-28

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1928

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1928, to May 9, 1928, that I last saw her alive on May 9, 1928, and that death occurred, on the date stated above, at 12:10 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Coronary Arteriosclerosis  
Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Epithelioma of face

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed)

Hugh Freyhe

M. D.

5/11/1928 (Address) 424 E North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery

DATE OF BURIAL

5/12 1928

ADDRESS

20 UNDERTAKER

Henry W. Mears Son 805 N. Calver



13930  
33810

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33810

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No.

JOHNS HOPKINS HOSPITAL

ST. 5-9 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Virginia Robinson

## (a) RESIDENCE NO.

419 McElderry

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 5

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Black

Single

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

8-31-27

AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Md

## 10 NAME OF FATHER

Silas Robinson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Irene Travis

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Va

14 Informant  
(Address)Records  
JOHNS HOPKINS HOSPITAL

15 Filed

1-1928

C. HAMPSON JONES, M.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1928

17

I HEREBY CERTIFY, That I attended deceased from  
May 9, 1928, to May 10, 1928,

that I last saw her alive on May 10, 1928,

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH\* was as follows:

Pertussis

(duration) yrs. mos. 19 ds.

CONTRIBUTORY  
(Secondary)

Convulsions - cause

not known

(duration) yrs. mos. 2 ds.

18 Where was disease contracted  
if not at place of death?

at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

None

(Signed)

J. C. Goodwin, M. D.

5/9, 1928 (Address)

Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Asbury Cem

DATE OF BURIAL

5/12/28 1928

UNDERTAKER

Byron Wright

ADDRESS

McElderry

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33811

33811

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 657 George

2. FULL NAME Ophelia Thompson

(a) RESIDENCE No. 657 George

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1905

AGE 23 Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) Goldsboro N.C. (State or country)

10 NAME OF FATHER Curley Thompson

11 BIRTHPLACE OF FATHER (city or town) N.C. (State or country)

12 MAIDEN NAME OF MOTHER Bertha Williams

13 BIRTHPLACE OF MOTHER (city or town) N.C. (State or country)

14 Informant Bertha Anderson (Address) 657 George St

15 Filed 1928 C. HAMPSON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1928

17 I HEREBY CERTIFY, That I attended deceased from February 10 1928 to May 9, 1928.

that I last saw her alive on May 9, 1928

and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis (Pulmonary)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY Tuberculosis (Pulmonary) (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1029 Madison Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Auburn Cem

5/12 1928

20 UNDERTAKER

ADDRESS

Byron Knight 1218 McElderry St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33812

## CERTIFICATE OF DEATH.

199 E 33812

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital, St. 76-37 Ward)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

## 4 Color or Race

## 5 Single, Married, Widowed, or Divorced, (write the word)

Male White married

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

## AGE

## Years

## Months

## Days

IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant

(Address)

## 15

Full

1928

C. HAMPSON JONES M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

192

## 17

I HEREBY CERTIFY that I took charge of the

remains described above, held an  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocarditis  
Fracture of skullCONTRIBUTORY  
(Secondary)

M. D.

(Address)

19

14376 Beray

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death:

Former or usual residence:

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Lynchburg Va

5/11 1928

## 20 UNDERTAKER

ADDRESS

E. J. Barty

Shutbury

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33813

E<sup>001</sup> 33813

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

EX

1-COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced

HUSBAND of  
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15

Filed

19

C. HAMPTON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

4-25, 1928, to 5-10, 1928

that I last saw him alive on 5-9, 1928

and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH\* was as follows:

Terminal Broncho Pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

5/10, 1928

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33814

## CERTIFICATE OF DEATH

90 E 33814

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 5601 Fairbairns Ave Ward 4)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Toolan(a) RESIDENCE NO. 5601 Fairbairns Ave Ward 4

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Mrs. Beane C. Toolan (or) WIFE of6 DATE OF BIRTH (month, day, and year) August 25 - 18927 AGE Years 35 Months 8 Days 15 IF LESS than 1 day hrs. or min..8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Lithographer (b) General nature of industry, business, or establishment in which employed (or employer) same (c) Name of employer Lin Decorating Co9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER John Toolan11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER Margaret August 5/1113 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland14 Informant Mrs. Beane C. Toolan (Address) 5601 Fairbairns Ave15 Filed 1928 C. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 192817 I HEREBY CERTIFY, That I attended deceased from May 9, 1928, to May 10, 1928, that I last saw him alive on May 9, 1928, and that death occurred, on the data stated above, at 3 a. m.The CAUSE OF DEATH\* was as follows: Chronic MyocarditisCONTRIBUTORY (Secondary) A number of years (duration) yrs. mos. da. Chronic Myocarditis A number of years (duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.19 28 (Address) Hamilton Baltimore Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial May 12 192820 UNDERTAKER Margaret L. Flynn ADDRESS 1422 Light

E 33815 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33815

## CERTIFICATE OF DEATH.

71-001

## 1-PLACE OF DEATH

TY OF BALTIMORE: (NO.

JOHNS HOPKINS HOSPITAL

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Michael Kluczynski

(a) RESIDENCE No.

1223 S. Dickerson

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

38 yrs. 2 mos. 26

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male white married

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

2/15/90

AGE

Years

Months

Days

If LESS than 1 day, hrs or min

38

2

26

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

John Kluczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Katherine Wieruski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Records

15

2-1928

C. HAMPTON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1928, to

May 10, 1928,

that I last saw him alive on

May 10, 1928,

and that death occurred, on the date stated above, at

900 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumococcus meningitis

(duration)

yrs.

mos.

ds. ?

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Clinical

(Signed)

I. R. Tumbke

M. D.

5/11/28 (Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Holy Rosary Cemetery May 14 1928

20 UNDERTAKER

ADDRESS

George A. Weber 2205 Bank St.

33816

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 S. Ann Street ST. 2-4 WARD)

2. FULL NAME Albina Kwasnik

(a) RESIDENCE No. 308 S. Ann Street ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)  
Female White InfantIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) June-29-1926

AGE Years Months Days If LESS than 1 day, hrs. or min.  
1 10 12

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER Theodore Kwasnik

11 BIRTHPLACE OF FATHER (city or town) Balto, Md.  
(State or country)

12 MAIDEN NAME OF MOTHER May Palanowski

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.  
(State or country)14 Informant Theodore Kwasnik  
(Address) 308 S. Ann Street

15 Filed 2-19-28 HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1928

17 I HEREBY CERTIFY, That I attended deceased from April 25 1928 to May 11 1928.

that I last saw her alive on May 11 1928, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Joseph Touhey M. D.

19 (Address) 2205 Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Rosary Cem. May 12 1928  
UNDERTAKER George A. Weber 2205 Bank St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33817

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 4-25 Ward)2-FULL NAME Clara Hutchins(a) RESIDENCE NO. 300 N. Eutaw St. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hutchins6 DATE OF BIRTH (month, day, and year) June 10th. 1861.7 AGE Years 66 Months 11 Days 1 IF LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.(State or country) Md.10 NAME OF FATHER Emanuel Mehlinger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany12 MAIDEN NAME OF MOTHER Babette Rice

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany14 Informant Mrs. Etta J. Mehlinger  
(Address) Eutaw Place.2 1926 C. HAMPSON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/ 192517 I HEREBY CERTIFY, That I took charge of the remains described above, held by Dr. Signey  
(Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said Dr. Signey  
(Inquest, autopsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Amputation of leg R-  
(duration) yrs. mos. ds. 1CONTRIBUTORY Post Op. Shock  
(Secondary) yrs. mos. ds. 1(Signed) G. C. Blakes M. D.  
(Address) 143 165 3 way

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Friendship Cem.Date of Burial 5/13/ 1928

20 UNDERTAKER

Nauid Sondheim ADDRESS 118 20 W mt. Royal Ave



3112  
33818

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)2. FULL NAME Henrietta Payer(a) RESIDENCE NO. 918 N. Caroline(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds.ST. 10-13 WARD

ST. WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) SingleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDATE OF BIRTH (month, day, and year) July 10 1872  
AGE 55 Years Months Days  
56 10 If LESS than 1 day. hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ind -10 NAME OF FATHER John Payer11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind -12 MAIDEN NAME OF MOTHER Martha Payer13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind -Informant (Address) Records -2-1928  
C. HAMPTON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 192817 I HEREBY CERTIFY, That I attended deceased from Apr. 17 1928 to May 10 1928, that I last saw her alive on May 10 1928, and that death occurred, on the date stated above, at 11 50 a.m.

The CAUSE OF DEATH\* was as follows:

Intestinal ObstructionEmergency case (duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) Pulmonary embolus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yrs. mos. ds.

Did an operation precede death? Yes Date of April 5 1928Was there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) J. E. Roman M. D.  
(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Olivet Cemetery

20 UNDERTAKER

Robt L. Turner and

DATE OF BURIAL

May 17 1928

ADDRESS

1442 N. Broadway

E 33819

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33819

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 910 E. Lombard St.

St. 3-5 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Patrick F. Moriarty

## (a) RESIDENCE NO.

910 E. Lombard St.

St. Ward

(Usual place of abode)  
Length of residence in city or town where death occurred 74 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 11th. 1853

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

75

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Ireland

## 10 NAME OF FATHER

Patrick Moriarty

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Mary Joyce.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

## 14

Informant

Miss Sarah Lee

(Address)

910 E. Lombard St.

## 15 Filed

10

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 11th.

28.

## 17

I HEREBY CERTIFY, That I attended, deceased from

May 5, 1928, to May 10, 1928.

that I last saw him alive on May 10, 1928.

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Cathedral Cemetery.

May 14th. 28.

FUNERAL

ADDRESS

Chas. P. Evans &amp; Son 118 W. Mt. Royal Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33820

E 33820

## CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO.

Y OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

RESIDENCE NO.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and state)

th of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if foreign birth?

yrs.

mos.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

Married

married, widowed, or divorced

HUSBAND of (or) WIFE of

Charles J. Davis

DATE OF BIRTH (month, day, and year)

Jan. 7. 1863

AGE

Years

65

Months

4

Days

3

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

Housework

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) (State or country)

Balto., Md.

10 NAME OF FATHER

Benjamin Garrison

11 BIRTHPLACE OF FATHER (city or town)

Balto., Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Isabelle Ringrose

13 BIRTHPLACE OF MOTHER (city or town)

Balto., Md.

(State or country)

Informant

Mrs. Croak (Haughton)

(Address)

1810 Bolton St.

2-1928

19

Registrar

16 DATE OF DEATH (month, day, and year)

May 10-28

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 10. 1924, to May 10, 1928.

that I last saw her alive on May 10, 1928.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Primary - Chronic Valvular Heart Disease  
To my knowledge about four or one half years  
Immediate - Hypostatic Pneumonia  
about 4 1/2

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed)

J. P. Stoney

M. D.

5-11-1928

(Address) 806 Hamilton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet Cemetery

May 12 1928

20 UNDERTAKER

ADDRESS

Margaret H. Fyfe

1422 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

33821

CERTIFICATE OF DEATH.

174 E 33821

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital Ward 7-9)

2-FULL NAME George L. Doenges

(a) RESIDENCE NO. 1906 McElderry St.        Ward       

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) married

6a If married, widowed, or divorced

HUSBAND of Anna M. Doenges  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11/1868

7 AGE Years 59 Months 9 Days 30 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Johns Hopkins

(c) Name of employer Hospital

9 BIRTHPLACE (city or town) Balto., Md.  
(State or country)

10 NAME OF FATHER Henry Doenges

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Dietrich

13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)

14 Informant Hospital  
(Address)

15 1928

19

John M. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Electrocution (High Tension Current)  
(Suicide)

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Chr. Myocarditis - Genl  
(Secondary) Arteriosclerosis (Autopsy)

(Signed) Joseph A. Adams M. D.  
(Coroner)

5/10/28 3006 B. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. ....mos. ....ds. In the State .....yrs. ....mos. ....ds.

was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Green Mount 5/12/28

20 UNDERTAKER ADDRESS

Joseph Adams 228 Bway



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33822

## CERTIFICATE OF DEATH.

E 33822

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

University Hospital 4-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Amanda Jenkins

## (a) RESIDENCE NO.

Gross Hall, Pasadena Md

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 2 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## SEX

Female

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

James Jenkins

## 6 DATE OF BIRTH (month, day, and year)

Nov 17 1891

## 7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

36

5

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Maryland

## 10 NAME OF FATHER

John Teyman

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Marionda Chaney

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## PARENTS

## 14

Informant  
(Address)Mr. James E. Jenkins  
Pasadena Md

## 15 Filed

C. H. JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1928

## 17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

find that said deceased came to death

(Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Operative for  
Ventral Hernia Mid abdomen.CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

(Signed)

August G. G. G.

(Coroner)

M. D.

5/10, 1928 (Address)

2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death

yrs.....mos.....ds.

In the

State

yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Maggie Cemetery

May 13, 28

## 20 UNDERTAKER

a. a. c. and

ADDRESS

John F. Denny

715 21st St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33823

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 33823

1-PLACE OF DEATH

City of BALTIMORE: (Name of City, Town, or Village) City Hospital St. 5-8 Ward

2-FULL NAME Robert Hust

(a) RESIDENCE NO. 627 76 Central St.        Ward       

(Usual place of abode)  
Length of residence in city or town where death occurred

80 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

male colored married

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

AGE 40 Years Months Days

1889

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

labor

9 BIRTHPLACE (city or town)

(State or country)

Arizona

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

un

14

Informant Willard Hust  
(Address) 513 Medford St

15 Filed....., 19

Registrar

### CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1928

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Ac Myocarditis

CONTRIBUTION Broken down pneumonia (Secondary)

May 10/28 (Signed) G. C. B. Adams (Coroner)

(Address) 14376 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Adams cemetery

20 UNDERTAKER

Edward Payson

Date of Burial

May 13 1928

ADDRESS 1631

Calverton

33824

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 ✓ E 33824

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Jenkins Memorial Hospital

REGISTERED NO.

City of BALTIMORE: (No.

1000 Caton Ave S. 14-70 Ward)

2-FULL NAME

Margaret A. Harman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1735 Linden Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frederick Harman

6 DATE OF BIRTH (month, day, and year)

9 year 1860

7 AGE

Years

Months

Days

IF LESS than 1 day...hrs. or...min..

68

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore Md

(State or country)

10 NAME OF FATHER

Wm. H. Tomblin

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Balt. Md

12 MAIDEN NAME OF MOTHER

Margaret Pearson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balt. Md

14

Informant (Address)

Jenkins Memorial Hosp 1000 Caton Ave

15

Date

1928

RPA

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 28, 1928, to May 10, 1928,

that I last saw her alive on May 10, 1928,

and that death occurred, on the date stated above, at 11:45 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Rectum

CONTRIBUTORY

(Secondary)

Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Ray &amp; Phys. Exam

(Signed) J. L. Delaplace, M. D.

. 19 (Address) St. Agnes Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Greenmount Cem May 14, 1928

20 UNDERTAKER

ADDRESS

A. Howard Evans 38 E. Fair

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33825

E 33825

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2641 E. Madison ST., 7-12 WARD)

## 2. FULL NAME

Joseph Monfalcone

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2641 E. Madison ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? 45 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE Male White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced

HUSBAND of

Margaret MonfalconeDATE OF BIRTH (month, day, and year) Oct. 7/66

AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

6172

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Chesapeake Marine Ry

BIRTHPLACE (city or town) (State or country)

Italy

## 10 NAME OF FATHER

Frank Monfalcone

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

## 12 MAIDEN NAME OF MOTHER

Beccelia

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

## 14

Informant (Address)

Margaret Monfalcone  
2641 E. Madison17 1928

, 19

RPK

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 19 28I HEREBY CERTIFY, That I attended deceased from Jan 10 19 28, to May 9 19 28.That I last saw him alive on May 9 19 28.and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows:

Mitral & Aortic Endocarditis  
Chronic Parenchymatous nephritis  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Krause, M. D., 19 (Address) 20 E. Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Parkwood5/12 19 28

## 20 UNDERTAKER

ADDRESS 2016Philip HernigQueens



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33826

33826

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin Sq. 10* St., *10* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *1513 E. Biddle*

(Usual place of abode)

Length of residence in city or town where death occurred *66* yrs. *7* mos. *2* ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Male*

4 Color of Face

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Oct 8 1861*

7 AGE

Years

Months

Days

IF LESS than

1 day hrs.

or min.

*66* *7* *2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Laborer*

9 BIRTHPLACE (city or town)

(State or country)

*Baexo*

10 NAME OF FATHER

*John M. Meher*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Mary Heller*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant

(Address)

*John M. Scherls*  
*1513 E Biddle St.*

15

Filing

19

*RRH*

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10 1928*

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Bichloride Mercury Poisoning*  
*Acute nephritis*

CONTRIBUTORY (Secondary)

Signed *John B. Norton* M. D.  
*1028* (Address) *Curtis Bay*

\*State the Disease Causing Death or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether accidental, Suicidal, or Homicidal. (See reverse for instructions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Baltimore Cemetery* *May 14 1928*

20 UNDERTAKER

ADDRESS

*George Schilling & Sons* *1126 E Monument*

33827

## HEALTH DEPARTMENT—CITY OF BALTIMORE

100-101 33827

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3039 E. Mount ST. 7-11 WARD)

2. FULL NAME Pearl L. Martin

(a) RESIDENCE NO. 3039 E. Mount ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

EX 4 COLOR OR RACE 5. Single, Married, Widowed, or Divorced, (write the word)

1. White SingleIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 14 / 28

AGE Years Months Days If LESS than 1 day, hrs. or min.  
3 26

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER Lafayette Martin11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany12 MAIDEN NAME OF MOTHER Estelle Paterson13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) W. Va.14 Informant Lafayette Martin  
(Address) 3039 E. Mount St.15 Filed 12-13-28, 19 HAMPSON JONES M. D.  
R. P. W. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 192817 I HEREBY CERTIFY, That I attended deceased from May 7, 1928, to May 10, 1928, that I last saw her alive on May 10, 1928, and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchitis Pneumonia.(duration) yrs. mos. 3 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James F. Fisher, M. D.  
5/11, 1928 (Address) 1823 N. Mount St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER Parkwood Cemetery May 14 1928  
George J. Puth ADDRESS 1735 Kearsley

E 33828 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33828

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 N Patterson Ph Ave ST., 8th WARD)

## FULL NAME

Mamie A. Harris

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

a) RESIDENCE NO. 1918 N Patterson Ph Ave

(Usual place of abode)

How long in U. S., if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

married, widowed, or divorced

HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) State or country

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant (Address)

2 1828

C. 19 HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY That I attended deceased from May 9, 1928 to May 11, 1928.

that I last saw her alive on May 11, 1928

and that death occurred, on the date stated above, at 4:50 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

May 1928 (Address) 1301 N Patterson Ph Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

33829

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001E 33329

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *4915 Park Heights Ave* ST. *7-56*)2. FULL NAME *Elizabeth T. Wilkerson*(a) RESIDENCE NO. *4915 Park Heights Ave* ST. *7-56*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

WARD

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced, (Write the word) *Married*a If married, widowed, or divorced HUSBAND or (or) WIFE of *William Wilkerson*DATE OF BIRTH (month, day, and year) *Aug 12, 1857*

AGE

Years *70*Months *8*Days *28*

If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) *Baltimore Md*10 NAME OF FATHER *John J. Matchett*

PARENTS

11 BIRTHPLACE OF FATHER (city or town, State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town, State or country) *Baltimore Md*

14

Informant (Address) *William Wilkerson 4915 Park Heights Ave*

15

2-1928

C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10 1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 6*, 1928, to *May 10*, 1928.that I last saw her alive on *May 10*, 1928.and that death occurred, on the date stated above, at *m.*

The CAUSE OF DEATH\* was as follows:

*Polar Pneumonia.*(duration) yrs. mos. *5* ds.CONTRIBUTORY (Secondary) *Acute Cardiac Dilatation*(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Harry Glassman, M. D.**May 19 28* (Address) *268 7th Ave NW*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *St. Luke*DATE OF BURIAL *5/12/28*20 UNDERTAKER *W. Cook*ADDRESS *582 E. North Ave.*



3830

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33830

## CERTIFICATE OF DEATH

—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Barclay ST. 17-14 WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Sarah M. Sinn

(a) RESIDENCE NO. 1602 Barclay ST., WARD \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

1 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Widowed

married, widowed, or divorced HUSBAND of Jacob C. Sinn (or) WIFE of

DATE OF BIRTH (month, day, and year) June 15, 1854

AGE Years 73 Months 10 Days 25 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work At Home

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) MD (State or country)

10 NAME OF FATHER John Umbarger

11 BIRTHPLACE OF FATHER (city or town) MD (State or country)

12 MAIDEN NAME OF MOTHER Muhmme

13 BIRTHPLACE OF MOTHER (city or town) MD (State or country)

Informant Charles W. Houch (Address) 1602 Barclay St

Filed 19 1928 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1928

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1928, to May 10, 1928, that I last saw her alive on May 7, 1928

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH\* was as follows: General Debility

CONTRIBUTORY (Secondary) Hypertensive Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death (duration) yrs. mos. ds.

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. D. Hancher, M. D.

, 19 (Address) 9 E. Biddle St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park DATE OF BURIAL 5/12/1928

20 UNDERTAKER Wm. C. Cook ADDRESS 502 E. North Ave

33831

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33831

PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1209 Balton

ST. 11-24

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

a) RESIDENCE NO. 1209 Balton

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

YE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of workb) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Informant

(Address)

Filed 2-19-28

19

Registrar

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
5/7/28, 1928, to 5/10/28, 1928,

that I last saw him alive on 5/10/28, 1928,

and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH\* was as follows:

Natural Pyrexia.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? 1/10 Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

5/11/28

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

ADDRESS

33832

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33832

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

Alder View ave ~~St. Paul~~ WARD

## 2. FULL NAME

Francis Farley.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

Alder View ave

(Usual place of abode)

Length of residence in city or town where death occurred

- yrs. 9 mos.

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth?

yrs. 9 mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

F.

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

Aug 21/1918

AGE

10

Years

Months

Days

If LESS than 1 day... hrs or min

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Schall

(b) General nature of industry, business, or establishment in which employed (or employer)

Hamilton

(c) Name of employer

Schall

BIRTHPLACE (city or town) (State or country)

Bingha. Tennessee. Bie.

## 10 NAME OF FATHER

Bernard Farley.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Princeton Va.

## 12 MAIDEN NAME OF MOTHER

Hona. Crockett.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Princeton Va.

14

Informant (Address)

Bernard Farley.

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1928, to May 10, 1928.

that I last saw her alive on May 9, 1928

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows:

measles

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical findings

(Signed)

Walter H. H. H.

M. D.

6/10, 1928 (Address) Maple Ave Belair Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

Parkwood Cemetery

DATE OF BURIAL

5/12 1928

20 UNDERTAKER

George J. Ruth

ADDRESS

1735 Harford ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33833

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1237 N. Gay ST. 8-17 WARD)

## 2-FULL NAME

Frederick Buchta

## (a) RESIDENCE NO.

1237 N. Gay

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5-Single, Married, Widowed, or Divorced, (write the word)

Male White married

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mary R. Buchta

DATE OF BIRTH (month, day, and year)

March 22-1883

AGE

Years

Months

Days

If LESS than 1 day, hrs or min

75

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Balt.

## 10 NAME OF FATHER

John Buchta

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt.

## 12 MAIDEN NAME OF MOTHER

Christina Buchta

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mary R. Buchta 1237 N. Gay

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 11 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 4, 1928, to May 11, 1928,

that I last saw him alive on May 11, 1928

and that death occurred, on the date stated above, at

9 A m

The CAUSE OF DEATH\* was as follows:

Senile Debility-

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Acute Bronchitis

(duration) yrs. mos. ds.

7

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. White, M. D. 5/12 1928 (Address) 2800 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak Lawn Cemetery

May 14, 1928

20 UNDERTAKER

ADDRESS

George F. Ruth 1735 Harford



33834

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33834

### 1-PLACE OF DEATH

CITY OF BALTIMORE: No. *3806 Turgum Rd*

### 2-FULL NAME

(a) RESIDENCE No. *3806 Turgum Rd*

(Usual place of abode)  
Length of residence in city or town where death occurred

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

If married, widowed, or divorced HUSBAND of (or) WIFE of *Albert G. Alford*

DATE OF BIRTH (month, day, and year) *Oct 4, 1859*

AGE Years Months Days If LESS than 1 day hrs. or min. *68 7 5*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Widow*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Cambridge Md.*

10 NAME OF FATHER *Wm S. Robinson*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *?*

12 MAIDEN NAME OF MOTHER *Margaret Reed*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Cambridge Md.*

14

Informant (Address) *Della Alford*

15

Filed

19 *21028* REGISTRAR *CHAMBERLAIN JONES M. D.*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9 1928*

17 I HEREBY CERTIFY, That I attended deceased from *May 27*, 1927, to *May 9*, 1928, that I last saw him alive on *May 6*, 1928, and that death occurred, on the date stated above, at *May 9*, 1928.

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency Chronic Nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *?*

Was there an autopsy? *no*

What test confirmed diagnosis? *Autopsy*

(Signed) *Louis M. Jones*

, 19

(Address) *15 Laver Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Lorraine Leem*  
*George Smith*

*May 12 1928*  
*Hollins*

E 33835

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33835

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *101-00*)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 5/17/28, to 5/18/28, 1928.

that I last saw him alive on 5/10/28, 1928.

and that death occurred, on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted (duration) yrs. mos. ds.

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

MAY 12 1928

C. HAMPSON JONES

Per

Mr. Calvary Cem  
Mrs. J. S. SacksMay 13 1928  
1302 Jefferson



## HEALTH DEPARTMENT—CITY OF BALTIMORE

33837

## CERTIFICATE OF DEATH

90 E 33837

PLACE OF DEATH

CITY OF BALTIMORE (No. *111 Mt Clare* ST. *18-29* WARD)FULL NAME *John H. Nogule*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

a) RESIDENCE NO. *111 Mt Clare* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Date of residence in city or town where death occurred *7* yrs. mos. ds.

How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

1 COLOR OR RACE *Male W* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Alice Nogule*DATE OF BIRTH (month, day, and year) *May 12, 1858*

AGE

Years *70*

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work *Miller*b) General nature of industry,  
business, or establishment in  
which employed (or employer)c) Name of employer *Shoemaker's Dohne*BIRTHPLACE (city or town)  
(State or country) *Baltimore Md*10 NAME OF FATHER *John Nogule*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *Elizabeth (Wahner)*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Baltimore Md*Informant  
(Address) *Lennard Nogule*  
*111 Mt Clare St*FILE NO. *1928*

G. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 12, 1928*

17

I HEREBY CERTIFY that I attended deceased from

*April 1, 1928*, to *May 12, 1928*that I last saw him alive on *May 2, 1928*and that death occurred, on the date stated above, at *3:35 A* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial degeneration*CONTRIBUTORY  
(Secondary) *arteriosclerosis*(duration) *1* mos. ds.(duration) *2* yrs. *7* mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Shepherd Dohne* M. D.19 (Address) *111 Mt Clare St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Mt Olivet Cem**May 15, 1928*

20 UNDERTAKER

ADDRESS

*77 W. Cook**302 E North St*



## 33838 HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 33838  
CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 N Caroline ST. 10-13 WARD)

2. FULL NAME Louis C. Bredehoeft.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 914 N Caroline

ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 57 yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced

HUSBAND of Matilda Reng.  
(or) WIFE of

DATE OF BIRTH (month, day, and year) Mar 28 1871

AGE Years 57 Months 2 Days 13 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Gustav Bredehoeft

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Marie Reng

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs. Matilda Bredehoeft  
(Address) 914 N Caroline St.

15 File No. 2-1828 C. HAMPTON JONES, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1928

17 I HEREBY CERTIFY, That I attended deceased from June 1926 to May 10 1928.

that I last saw him alive on June 9 1928

and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH\* was as follows:

Coronary aneurysm

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) [Signature] M. D.

19 (Address) 1125 N. [Address]

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

Parkwood Ceme John Allrich

DATE OF BURIAL

May 14 1928

ADDRESS

208 E. [Address]

# 3839 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sinai Hospital 5-8* ST. *5-8* WARD)

REGISTERED NO. *33839*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Esther Malman*

(a) RESIDENCE NO. *1000 E. Balto.* ST. *5* WARD *28*

(Usual place of abode)  
Length of residence in city or town where death occurred *25* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *25* yrs. *0* mos. *0* ds.

### PERSONAL AND STATISTICAL PARTICULARS

EX. 4 COLOR OR RACE *Female white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

If married, widowed, or divorced HUSBAND of (or) WIFE of *Abraham Malman*

DATE OF BIRTH (month, day, and year) *1900*

AGE Years *50* Months *—* Days *—* If LESS than 1 day, hrs. *—* or min. *—*

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Russia*

10 NAME OF FATHER *Isaac Stulman*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*

12 MAIDEN NAME OF MOTHER *Etta*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

PARENTS

14 Informant *Abraham Malman* (Address) *1000 E. Balto.*

15 Filed *13 1928* Registrar *W. M. Jones*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/12* 19 *28*

17 I HEREBY CERTIFY, That I attended deceased from *4/22/1928* to *5/12/1928*, that I last saw her alive on *5/12/1928* and that death occurred, on the date stated above, at *5:45* m.

The CAUSE OF DEATH\* was as follows:  
*Chronic myocarditis*  
*Chronic myocarditis*

CONTRIBUTORY (Secondary) *Pneumonia* (duration) yrs. *—* mos. *—* ds.

18 Where was disease contracted if not at place of death? *—*

Did an operation precede death? *no* Date of *—*

Was there an autopsy? *no*

What test confirmed diagnosis? (Signed) *Henry Ginsburg* M. D. (Address) *Sinai Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Hebrew Mt. Carmel*

DATE OF BURIAL *5/13* 19 *28*

20 UNDERTAKER *Isaac Lewis 1439 E. Balto.*

33840

HEALTH DEPARTMENT—CITY OF BALTIMORE

33840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Valley ST. 9-18 WARD)

2-FULL NAME

(a) RESIDENCY NO. 311 Valley ST. (Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Indian

If married, widowed or divorced HUSBAND of (or) WIFE of George J. Stewart

DATE OF BIRTH (month, day, and year) 11-15-1853

AGE 74 Years Months 5 Days 75 4 26 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant Mrs. E. D. Lewis (Address) 1311 Valley ST.

15

13 1928 HANCOCK JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 14- 1928 to May 11- 1928, that I last saw her alive on May 11, 1928, and that death occurred, on the date stated above, at 10-21 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? w Date of

Was there an autopsy? w

What test confirmed diagnosis? none

(Signed) E. Bell Hall, M. D.

May 11, 1928 (Address) 1631 E North St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOV.

DATE OF BURIAL

Columbus Ohio

5/13 1928

20 UNDERTAKER

ADDRESS

John Lewis 1439 E. 1st St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Balto General Hospital*)

## 2. FULL NAME

(a) RESIDENCE NO. *916 N. Broadway*

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. mos. ds.REGISTERED NO. *171 E 33841*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If not resident give city or town and State) *60* yrs. mos. ds. How long in U. S., if of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced, (write the word) *Married*If married, widowed, or divorced HUSBAND of (or) WIFE of *Cecelia Fink*DATE OF BIRTH (month, day, and year) *June 18, 1878*AGE Years *70* Months *—* Days *—* If LESS than 1 day. hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Tailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Nathan Fink*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Berkman*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*Informant *Cecelia Fink* (Address) *916 N. Broadway*

15

Filed *May 13 1928*Registrar *R. R. R.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13 1928*17 I HEREBY CERTIFY, that I attended deceased from *April 18, 1928* to *May 13, 1928*. That I last saw him alive on *May 13, 1928*, and that death occurred, on the date stated above, at *5:15 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*Traumatic amputation of penis (duration) yrs. mos. ds. *2* CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *25*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of?Was there an autopsy? *No*What test confirmed diagnosis? *Clin. Exam*(Signed) *Louis T. Lang* M. D. *May 13, 1928* Address *W. Balto Gen Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

*Hebrew Mass Rd**5/13, 28*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1409 E. 11th St*



E 33842

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33842

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

BALTIMORE CITY HOSPITAL ST. \_\_\_\_\_ WARD \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Ella Daniels

(a) RESIDENCE No. 600 W. Madison Road WARD \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) 8/63  
AGE Years Months Days If LESS than 1 day, hrs or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER J. W. Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant (Address) Reverend

15 Filed \_\_\_\_\_, 19 \_\_\_\_\_ Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/1928

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1928, to May 11, 1928, that I last saw her live on May 11, 1928, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH\* was as follows:

Myocarditis, coronary atherosclerosis, hypertensive  
(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? yes

What test confirmed diagnosis? General & Special  
(Signed) C. Holmes Boyd, M. D., 19 \_\_\_\_\_ (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
ROYAL Holy Cross R. P. Co.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

502 E. North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33843

## CERTIFICATE OF DEATH.

44E 33843  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2516 Maryland Ave* ST. *12* WARD)

## 2-FULL NAME

*William Thomas Wilson*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2516 Md. Ave.*ST. *12* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *48* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *M.*4 COLOR OR RACE *N.*

5 Single, Married, Widowed

or Divorced, (write the word)

*Married*

If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Mary Ely Wilson*DATE OF BIRTH (month, day, and year) *May 4-1856*

AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*72 2 8*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Watchman*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*Thomas C. Wilson*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Baltimore*

12 MAIDEN NAME OF MOTHER

*Brandy Reese*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*York Pa*

14

Informant  
(Address)*Mrs Mary Ely Wilson*  
*2516 Md Ave*

15

Filed

19

*W. J. Jones, M. D.*  
*W. J. Jones*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 12 1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 11 1928* to *May 12 1928* that I last saw him alive on *May 11 1928*and that death occurred, on the date stated above, at *1:45 A* m.

THE CAUSE OF DEATH\* was as follows:

*Cardiac dilatation*  
*hypostatic pneumonia**undetermined* (duration) yrs. mos. ds.CONTRIBUTORY *Carcinoma**undetermined* (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

*Clinical findings*(Signed) *Dr Frank S Humphrey* M.D., 19 (Address) *2512 Maryland Ave*

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cemetery**5/15 1928*

20 UNDERTAKER

ADDRESS

*Wm Cook**502 E North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33844

## CERTIFICATE OF DEATH.

88 ✓  
E 33844  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital 27-37 St. 27-37 Ward 27-37)2-FULL NAME Margaret B Zoller(a) RESIDENCE NO. 4106 Eastern

(Usual place of abode)

St. 27-37 Ward 27-37Length of residence in city or town where death occurred Life yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 Color or race White 5 Single, Married, Widowed, or Divorced, (write the word) Divorced6a If married, widowed, or divorced (or) WIFE of John J. Zoller6 DATE OF BIRTH (month, day, and year) Nov 7- 18657 AGE Years 62 Months 6 Days 9 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Balto Md10 NAME OF FATHER Ed Beum

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany12 MAIDEN NAME OF MOTHER Unkown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unkown14 Informant John Zoller(Address) 4102 Eastern Ave15 Filed....., 19 May 11

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 193817 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquestand that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Ac MyocarditisBroken down (duration) yrs. mos. ds.CONTRIBUTION (Secondary) May 10 (Address) 143 101 Bway12/10/14 (Address) 143 101 Bway12/10/14 (Address) 143 101 Bway12/10/14 (Address) 143 101 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR Date of Burial

Western Cemetery 5/17 192820 UNDERTAKER W B CookADDRESS 502 E Nrd

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33845

## CERTIFICATE OF DEATH.

31 E 33845

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balto City Hospital* ST. *4* WARD)2-FULL NAME *Helena Wiczulicz*(a) RESIDENCE No. *421 S. Bond*  
(Usual place of abode)Length of residence in city or town where death occurred *Life* mos. ds.

ST.

WARD

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *7* 4 COLOR OR RACE *W -* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*If married, widowed, or divorced  
HUSBAND of  
or) WIFE of *John Wiczulicz*DATE OF BIRTH (month, day, and year) *1908*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*20*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) *Balto Maryland*10 NAME OF FATHER *Frank Fredrick*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Poland*12 MAIDEN NAME OF MOTHER *Anna Presz*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Poland*14 Informant  
(Address) *Hospital Record*

15

Filed *13 1928*

HARRISON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10 1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 5 1928* to *May 10 1928*, that I last saw her alive on *May 10 1928* and that death occurred, on the date stated above, at *11:20 A.M.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary tuberculosis**Unknown* (duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? *Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chemical & Lab*(Signed) *L. E. Madden* M. D.(Address) *Balto City Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Holy Rosary*

UNDERTAKER

*William J. Anderson*

DATE OF BURIAL

*5/14 1928*

ADDRESS

*1618 Eastern Ave*



13793

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33846

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Wiegulis

(a) RESIDENCE NO. 421 S Bond

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female white-

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) 4-20-28

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

32 weeks

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Informant

(Address)

Filed

1928

19

H. A. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 19 28

17

I HEREBY CERTIFY, That I attended deceased from

May 5 19 28, to May 10 19 28,

that I last saw her alive on May 10 19 28,

and that death occurred, on the date stated above, at 6 05 p. m.

The CAUSE OF DEATH\* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) L. C. Woodwin M. D.

5/11, 1928 (Address) Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Holy Rosary  
J. J. G. 1618 Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33847

CERTIFICATE OF DEATH.

66 E 33847

1-PLACE OF DEATH

City of BALTIMORE: (No. 1436 N. Bond St St. 8-17 Ward)

2-FULL NAME

Robert McCleary

(a) RESIDENCE NO.

1436 N. Bond St

St. Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)  
Length of residence in city or town where death occurred life mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) lower

6a If married, widowed, or divorced  
HUSBAND of  
(or WIFE of) Lilian Knowles

6 DATE OF BIRTH (month, day, and year) May 17/1868

7 AGE Years 59 Months 11 Days 24 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Valve Co

9 BIRTHPLACE (city or town) Balto., Md.  
(State or country)

10 NAME OF FATHER Wm McCleary

11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)

12 MAIDEN NAME OF MOTHER Anna R. Coleman

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.  
(State or country)

14 Informant Geo. R. McCleary  
(Address) 1223 Linden Ave

15 Filed May 13 1928 HAMPTON JONES, M. D.  
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death  
(Inquest, autopsy or inquiry.)

on the day stated above.  
The CAUSE OF DEATH\* was as follows:

Cardiac Failure—Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.  
(Signed) [Signature] M. D.  
(Coroner)

5/12/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Baltimore Cemetery May 14 1928  
20 UNDERTAKER Harry W. Ehlert ADDRESS 1024 E. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33848

## CERTIFICATE OF DEATH.

E 33848

## 1-PLACE OF DEATH

CITY OF BALTIMORE

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
to  
that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Carcinoma of Small  
IntestineCONTRIBUTORY (Secondary)  
(duration) yrs. mos. ds.  
Intestinal Obstruction18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of 4/30/28

Was there an autopsy? No

What test confirmed diagnosis? Operative & Chemical  
(Signed) H. H. Humphreys M. D.

5/13, 1928 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33849

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD \_\_\_\_\_)

## 2. FULL NAME

(a) RESIDENCE No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX \_\_\_\_\_ 4 COLOR OR RACE \_\_\_\_\_ 5 Single, Married, Widowed, or Divorced, (write the word) \_\_\_\_\_

If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) \_\_\_\_\_

AGE \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, hrs. or min. \_\_\_\_\_

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_

10 NAME OF FATHER \_\_\_\_\_

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_4 Informant \_\_\_\_\_  
(Address) \_\_\_\_\_

Filed \_\_\_\_\_

Registrar \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) \_\_\_\_\_

17

I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_  
\_\_\_\_\_ to \_\_\_\_\_,  
that I last saw him alive on \_\_\_\_\_,  
and that death occurred, on the date stated above, at \_\_\_\_\_

The CAUSE OF DEATH\* was as follows:

Pneumococci  
Meningitis  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.CONTRIBUTORY  
(Secondary) \_\_\_\_\_

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted \_\_\_\_\_  
if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) \_\_\_\_\_

5/12/1928 (Address) \_\_\_\_\_

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



33850

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home &amp; Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

Pannumary &amp; Broadway

ST.

WARD)

2-FULL NAME

Mr Charles Howard

(a) RESIDENCE NO.

+ 09 Hollin Road (Ohio)

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

7

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

Mch. 26/1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

1

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ohio

10 NAME OF FATHER

Albertus B Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Frederic Md

12 MAIDEN NAME OF MOTHER

Mary L. Fay

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Barnsville O.

14

Informant (Address)

Isaac Walker 409 Hollin Rd Evans Md

15

Filed

MAY 13 1928

J. M. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 9, 1928, to May 13, 1928,

that I last saw him alive on May 13, 1928,

and that death occurred, on the date stated above, at 3.25 a m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History, physical exam.

(Signed) J. Frank Herriot M. D.

May 13 1928 (Address) Church Home &amp; Infirmary

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Barnesville Ohio May 13 1928

20 UNDERTAKER

ADDRESS

Chas. E. Franck 802 Madison Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33851

## CERTIFICATE OF DEATH

E 33851

PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

Ruth S. Le Fever

a) RESIDENCE NO.

1824 Buckhaman

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

single

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

3-5-98

YE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

30

2

8

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work

office asst

b) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Lancaster Pa

10 NAME OF FATHER

Harry R. Le Fever

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Pa

12 MAIDEN NAME OF MOTHER

Anna Good

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Pa

Informant

(Address)

Records

JOHNS HOPKINS HOSPITAL

Filed

19

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-12-28

17

I HEREBY CERTIFY, That I attended deceased from

May 10, 1928, to May 12, 1928

that I last saw him alive on May 12, 1928

and that death occurred, on the date stated above, at 5:15 p.m.

The CAUSE OF DEATH\* was as follows:

Brain Tumor, of Brain  
Stem, Glioma (Benign)

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Lancaster Pa

Did an operation precede death? yes Date of May 12, 1928

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy, Operation

(Signed) J. S. Conner, M. D.

5/13, 1928 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Lancaster Pa

5/13 1928

20 UNDERTAKER

ADDRESS

J. S. Conner, Son, Pa. No ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33852

## CERTIFICATE OF DEATH.

REGISTERED NO.

66 E 33852

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *On Way to Mercy Hospital*)2-FULL NAME *Mrs. Nancy R. Smith*(a) RESIDENCE NO. *1120 St. Paul*

(Usual place of abode)

Length of residence in city or town where death occurred *46* yrs. *5* mos. *25* ds.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 Color or Race

Female

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

46

36

5

25

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Secretary

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

C. H. King

Baltimore

10 NAME OF FATHER Henry A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

Mary A. Twomey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant (Address)

Mrs. Katherine H. Ridgely

15 Filed *13 1928* *HARRISON JONES, M. D.* Registrar

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery

20 UNDERTAKER

Henry W. Mears &amp; Son 805 N. Calver

ADDRESS

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Acute Alcoholism

CONTRIBUTORY (Secondary)

Acute Cardiac Distention

(Signed) *W. C. Cline* 1928 Address

(Coroner)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *Couple hours* yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33853

## CERTIFICATE OF DEATH.

31 E 33853

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 Gilman ST., 15-22 WARD)

## 2-FULL NAME

Emma A. Speers

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1324 Gilman ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

12 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored

Married

If married, widowed, or divorced

HUSBAND of (or) WIFE of

Charles Speers

DATE OF BIRTH (month, day, and year)

July 8-1900

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

28

1

2

12

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

1846 Pa. Ave. Seaford

BIRTHPLACE (city or town) (State or country)

West River Md

## 10 NAME OF FATHER

Sylvester W. Gowan

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

West River Md

## 12 MAIDEN NAME OF MOTHER

Ida Gowan

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

West River Md

Informant

(Address)

Ida Gowan 1324 Gilman ST

Filed

19

HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 10 1928

17

I HEREBY CERTIFY, That I attended deceased from

Feb 15 1928, to July 10 1928,

that I last saw her alive on July 9 1928

and that death occurred, on the date stated above, at 9.45 A.M.

The CAUSE OF DEATH\* was as follows:

Phthisis (Pulmonary)

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. H. Wright, M. D.

11, 1928 (Address) 1209 Princeton St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

West River Md

May 13 1928

20 UNDERTAKER

ADDRESS

Thomas E. Nelson

1324 Gilman St



33854

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

45 E 33854

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

16 DATE OF DEATH (month, day, and year)

19

5a If married, widowed, or divorced  
husband of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 Filed

13 1928

16

LAWSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

Apr 24, 1928, to May 10, 1928.

that I last saw her alive on May 10, 1928.

and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Rectum  
(duration) Unknown

## CONTRIBUTORY

(Secondary)

Surgical Shock  
(duration) 30 min

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS



33856

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

101-001 E 33856

PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.)

ST. 17-25

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

Curtis Austin

a) RESIDENCE NO.

611 N. Park

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1 yrs.

mos.

ds.

How long in U. S. if foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

X

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Male

Colored

Married

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Essee

DATE OF BIRTH (month, day, and year)

March 10, 1928

YE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

25

2

1

## OCCUPATION OF DECEASED

a) Trade, profession or  
particular kind of work

Laborer

b) General nature of industry,  
business, or establishment in  
which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

North Carolina

10 NAME OF FATHER

Curtis Austin

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Helen Johnson

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

North Carolina

Informant

(Address)

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 11, 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 9, 1928, to May 11, 1928,

that I last saw him alive on May 11, 1928

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH\* was as follows:

acute lobar pneumonia  
complete left, type II  
pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY  
(Secondary)

acute upper respiratory infect

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed)

S. G. Stewart, M. D.

5/11, 1928 (Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Mount Zion

DATE OF BURIAL

5-14 1928

20 UNDERTAKER

Joseph A. Livch

ADDRESS

409 Mount

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33857

31 E 33857

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Monk Hope Retreat* ST. *28-113* WARD *28*)2-FULL NAME *Alice Josephine Walsh*(a) RESIDENCE NO. *Monk Hope Retreat* ST. *28-113* WARD *28*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1*mos. *24*ds. *24*How long in U. S., if of foreign birth? *Life*yrs. *—*mos. *—*ds. *—*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single -*If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *X*DATE OF BIRTH (month, day, and year) *Sept 30, 1897*

AGE

Years *30*Months *0*Days *7*If LESS than  
1 day, hrs. *12*  
or min. *0*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Religious Teacher*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Soc of Charity*

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)*New York - Utica*10 NAME OF FATHER *Luke Walsh*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Co Mayo**Ireland -*12 MAIDEN NAME OF MOTHER *May Conroy*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Co Mayo**Ireland -*

14

Informant  
(Address)*Records of Monk Hope Retreat  
Baltimore Md -*

15

Filed

19

*HARRISON JONES, M.D.*  
*R.A.H.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 12 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*March 3rd*, 1928, to *May 12*, 1928,  
that I last saw her alive on *May 11*, 1928,  
and that death occurred, on the date stated above, at *12:35 a.m.*

The CAUSE OF DEATH\* was as follows:

*Dementia Praecox*(duration) *5* yrs. *0* mos. *0* ds.CONTRIBUTORY  
(Secondary)*Tuberculosis -*(duration) *0* yrs. *4* mos. *0* ds.18 Where was disease contracted  
if not at place of death? *Baltimore Md -*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery*, M. D., 19 (Address) *Monk Hope Retreat*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*St. Stephens Cemetery* *May 14, 1928*

20 UNDERTAKER

ADDRESS

*Stewart & Thomas* *Balto.*





# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33859

## CERTIFICATE OF DEATH.

129 E 33859

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 South Eden ST. 5-X WARD)

2-FULL NAME Henry Clay Horner

(a) RESIDENCE NO. 546 North Bay ST. 61 WARD 29

(Usual place of abode) Length of residence in city or town where death occurred 61 yrs. 0 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of of the late Sophia L. Horner

DATE OF BIRTH (month, day, and year) Apr 12 1867 AGE Years 61 Months 0 Days 29 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electr. Highway

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer Dept

(c) Name of employer Balto City Md

BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER John H. Horner

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

4 Informant James Arthur Horner (Address) 16 South Eden St

5 Filed 13 1928 H. JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1928

17 I HEREBY CERTIFY, That I attended deceased from May 1 1928 to May 11 1928 that I last saw him live on May 10 1928 and that death occurred, on the date stated above, at 6.40 a. m.

The CAUSE OF DEATH\* was as follows: Interst. Nephritis

CONTRIBUTORY (Secondary) C. Lauston (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 1 ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Hy. Ex

(Signed) J. G. Brades M. D.

19 (Address) 1436 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park DATE OF BURIAL 5/15/28

20 UNDERTAKER Geo. Weber & Son 2503 E. Monument Ave

3739

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

33860

—PLACE OF DEATH

CITY OF BALTIMORE: (No.

—FULL NAME

a) RESIDENCE NO.

(Usual place of abode)

Age of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6 married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years Months Days 8 If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant

(Address) JOHNS HOPKINS HOSPITAL

Filed

19 1928 REGISTRAR

ST. L. H. H. WARD

WARD

(If non-resident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1928, to May 11, 1928.

that I last saw him alive on May 11, 1928.

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH\* was as follows:

*Chronic rheumatic endocarditis (mitral stenosis & insufficiency & aortic)*

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) *Myocardial failure, causing**decompensation* (duration) yrs. 14 ds.

18 Where was disease contracted

if not at place of death? *At Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical examination*(Signed) *George B. Finney* M. D.May 11, 1928 (Address) *Johns Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St. Pauls Violetteville Md 5/15/1928*

20 UNDERTAKER

ADDRESS

*Gr. Weber Son 2503 Edmondson*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

3861

33361

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

16 DATE OF DEATH (month, day, and year)

Female

White

Widowed

5/12 1928

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day or

18 CAUSE OF DEATH\* was as follows

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

I HEREBY CERTIFY That I attended deceased from

5/12, 1928, to 5/12, 1928

that I last saw him alive on 5/12, 1928

and that death occurred, on the date stated above, at 10:15 P. M.

18 CAUSE OF DEATH\* was as follows

Cerebral hemorrhage

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease causing death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS





# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33863

✓ 33863.

129

E 33863

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1128 Spring Hill Ave* ST. *17* WARD *4*)

### 2-FULL NAME

*Ellie Curry*

(a) RESIDENCE NO. *1128 Spring Hill*

(Usual place of abode)

ST. *17*

WARD *4*

Length of residence in city or town where death occurred *2* yrs. *2* mos. *7* ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. *2* mos. *7* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *C* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of *Hubert Curry*

DATE OF BIRTH (month, day, and year) *1890*

AGE Years *58* Months *1* Days *7* If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Charles C. Md*

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER *Mary Thomas*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

PARENTS

14 Informant *Mrs. Mamie Gray* (Address) *1128 Spring Hill Ave*

15 Filed *1928* Registrar *Reck*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11 1928*

I HEREBY CERTIFY, That I attended deceased from *Apr 15 1928* to *May 11 1928* that I last saw her alive on *May 11 1928* and that death occurred, on the date stated above, at *2 P* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*

(duration) *1* yrs. *3* mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Urinary*

(Signed) *J. J. Smith* M. D. 5/13/28 (Address) *1126 Spring Hill*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *La Plata Md.*

DATE OF BURIAL

20 UNDERTAKER

*Mrs. A. G. Elliott*

ADDRESS

*1725 Ashland*

**E 33864**

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 763 W. Mulberry St. 4-76 Ward)2-FULL NAME Samuel Ray(a) RESIDENCE NO. 763 W. Mulberry St. 4-76 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 1/2 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Negro 5 Single, Married, Widowed, or Divorced, (write the word) Married3a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanch Ray6 DATE OF BIRTH (month, day, and year) May 15 18907 AGE Years 37 Months 11 Days 24 IF LESS than 1 day.....hrs. or.....min.8 OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town) Balto.  
(State or country)10 NAME OF FATHER John R. Ray.11 BIRTHPLACE OF FATHER (city or town) Balto.  
(State or country)12 MAIDEN NAME OF MOTHER Louisa Smith13 BIRTHPLACE OF MOTHER (city or town) Balto.  
(State or country)14 Informant Mrs. Blanch Ray  
(Address) 763 W. Mulberry St.

15 Filed..... 19

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Suicide.  
Poisoned by CO. Inhaled illuminating gas.

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Signed) L. J. Zeller M. D.  
(Coroner)5/9/1928 (Address) 2739 Eastern Ave.,

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR Date of Burial

20 UNDERTAKER

ADDRESS

Mrs. R. G. Elliott May 13, 1928  
1725 Ashland

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33865

## CERTIFICATE OF DEATH.

161-001

E 33865

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital* ST., *13* WARD)

2. FULL NAME *Virginia June Muehlberger*

(a) RESIDENCE NO. *2034 East Chare* ST., WARD

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? (If non-resident give city or town and State) yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX *7* 4 COLOR OR RACE *N* 5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *5-11-28*

AGE Years Months Days If LESS than 1 day, 4 hrs or 3 min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Baltimore* (State or country) *Ind.*

10 NAME OF FATHER *James Muehlberger*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Ind.*

12 MAIDEN NAME OF MOTHER *Elizabeth Pfister*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Ind.*

14 Informant *James Muehlberger* (Address) *2034 East Chare St.*

15 *141928C* *19* *HARRISON JONES, M. D.* Registrar

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-12-28*

17 I HEREBY CERTIFY, That I attended deceased from *5-11-*, 19 *28*, to *5-12-*, 19 *28*.

that I last saw her alive on *5-12-*, 19 *28*, and that death occurred, on the date stated above, at *12:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Premature 6 mo.*

(duration) yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Clinical*

(Signed) *H. Lawrence Fahnestock, M. D.*

, 19 (Address) *St Joseph Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*St Casper Cem.* *May 14, 1928*  
*Mrs C. Miller* *2334 Jeff*



1321 E 33866

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

113 E 33866

—PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No.)

ST. 1-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME John King

(a) RESIDENCE NO. 644 S. Belmored

ST. 1

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

X 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Baby

married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year) 3/5/28

Years Months Days If LESS than 1 day, hrs. or min.  
7 weeks 2 7

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country) Ind

10 NAME OF FATHER John King

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Ind

12 MAIDEN NAME OF MOTHER Helen Lisels

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) IndInformant Cecelia  
(Address) Johns Hopkins Hospital

Filed

May 14 1928

HAMILTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12-1928

17

I HEREBY CERTIFY, That I attended deceased from

April 17, 1928, to May 12, 1928.

that I last saw him alive on May 12, 1928

and that death occurred, on the date stated above, at 1:45 P. M.

The CAUSE OF DEATH\* was as follows:

Marasmus

CONTRIBUTORY (duration) yrs. 2 mos. ds.

(Secondary) Diarrhea (unspecified) stationer

(duration) yrs. 9 mos. ds.

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. B. Bennett, M. D.

May 12, 1928 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

St Stanislaus Cem

DATE OF BURIAL

May 14 1928

20 UNDERTAKER

Stephen H. Fialkowski

ADDRESS

Greenwood

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**E 33867**

## CERTIFICATE OF DEATH.

100-001

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3606 Parkdale Ave ST. 35 WARD)

2-FULL NAME William Edgar Fisher

(a) RESIDENCE NO. 3606 Parkdale Ave ST. 35 WARD

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED **E 33867**  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of Child

DATE OF BIRTH (month, day, and year) Jan 29 1928  
AGE Years 3 Months 14 Days 13 If LESS than 1 day, hrs. or min.

### OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) md.

10 NAME OF FATHER Raymond E. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Evelyn Aulden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

Informant Raymond E. Fisher (Address) 3606 Parkdale Ave

Filed

1928 C. HAYSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1928

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1928, to May 11, 1928, that I last saw her alive on May 11, 1928, and that death occurred, on the date stated above, at 406 m. The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds. 2 CONTRIBUTORY (Secondary) otitis Media (bilat)

(duration) — yrs. — mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No - Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam'n  
(Signed) S. A. Dadds M. D.

May 13 1928 (Address) 904 N Charles St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Marys Hospital

May 14, 1928

20 UNDERTAKER

ADDRESS

Chenoweth

3615 Chestnut

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33868

## CERTIFICATE OF DEATH.

129 E 33868

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

BALTIMORE CITY HOSPITAL

ST.

WARD)

2-FULL NAME *Frederick Bunchheart*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. *4012 Church* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *7* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *7* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*If married, widowed, or divorced HUSBAND of or) WIFE of *?*DATE OF BIRTH (month, day, and year) *?*AGE Years *80* Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Frederick Bunchheart*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Elyselet?*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*4 Informant (Address) *Records*15 Filed *1923* 19 Registrar *R.M.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/11/1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 7, 1928* to *May 11, 1928*, that I last saw him live on *May 11, 1928* and that death occurred, on the date stated above, at *4:50 P. m.*

The CAUSE OF DEATH\* was as follows:

*myocarditis, chronic. arteriosclerosis. interstitial nephritis, chronic.*(duration) *?* yrs. *0* mos. *0* ds.CONTRIBUTORY *Bunch pneumonia* (Secondary)(duration) *?* yrs. *0* mos. *2* ds.18 Where was disease contracted if not at place of death? *?*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *General & Sub.*(Signed) *E. H. Lewis Boyd*, M. D. (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St. Mary's Hospital May 14, 1928*

20 UNDERTAKER

ADDRESS

*St. S. Marshall 3539 Fall Road*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33869

**E 33869**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *City Hospital* St., *12* Ward *12*)

2-FULL NAME Nary Bagdow

(a) RESIDENCE NO. 1048 10<sup>th</sup> Gay St. Ward

(Usual place of rhode)

Length of residence in city or town where death occurred 23 yrs

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. da

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 Color or Race White	5 Single, Married, Widowed, or Divorced, (write the word) Married
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5a ~~IF married, widowed, or divorced~~  
~~HUSBAND of~~  
(or) WIFE of *la f' B " 1.*

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
44				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... *House work*

(b) General nature of industry, business, or establishment in which employed (or employer)..... *— 37*

(c) Name of employer.....

9 BIRTHPLACE (city or town).....  
(State or country).....

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town).....  
(State or country)

12 MAIDEN NAME OF MOTHER *Posthumous*

13 BIRTHPLACE OF MOTHER (city or town), .....  
(State or country) *California*

14 Informant Ignatius Beglov  
(Address) 148 N. 4th St.

16 Filed..... 19.....  
Registrar

### CONOR'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1921

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

(thereon and from the evidence obtained by said ..... Inquest au-  
Inquiry ..... and that said deceased came to her death  
topsy or inquest.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Ac Myocarditis

(duration) ..... yrs. .... mo.

CONTRIBUTORI  
(Seconda)

May (duration) yrs. mos. ds.  
(Signed) H. C. Hader M. D.  
(Coroner)

(Address) 143 N. Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

**15 LENGTH OF RESIDENCE** (For Hospitals, Institutions, Trans-  
lents, or Recent Residents)

At place ..... In the  
of death.....yrs.,.....mos.,.....ds. State..... yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death.....

former or usual residence.....

19	PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
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Robert L. Turner Inc 71442

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## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33871

## CERTIFICATE OF DEATH.

90 E 33871

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *222 Roland Ave* ST. *77* WARD)2. FULL NAME *William E. Wiegand M.D.*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *above*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred *75* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *M*4 COLOR OR RACE *N*5 Single, Married, Widowed, or Divorced, (write the word) *Married*

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Emma Florence Green Wiegand*7 DATE OF BIRTH (month, day, and year) *Apr 25 1853*

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*75**0**18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Physician*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*10 NAME OF FATHER *W. E. Wiegand*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Baltimore Md.*12 MAIDEN NAME OF MOTHER *Louisa Hewitt*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Chesterton Kent Co Md.*

14

Informant  
(Address)*Henry H. Wiegand*  
*222 Roland Ave*

15

Filed

*CHAS. H. JONES, M.D.*  
*Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/13 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*5/17*

, 19

*5/13*, 19 *28*that I last saw him alive on *5/12*, 19 *28*and that death occurred, on the date stated above, at *11:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Pectoris*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)*Myocarditis Valv. Les.*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*Henry H. Wiegand M.D.**5/13 1928* (Address) *upland St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*London Park Cem**May 15 1928*

20 UNDERTAKER

ADDRESS

*Henry Jenkins & Co.**Chesapeake*  
*400 Cold Spring*

MAY 14 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33872

## CERTIFICATE OF DEATH.

Registered No. 33872

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 216 Otterheim St. 21-79 Ward)

## 2-FULL NAME

(a) Residence No. 216 Otterheim St. (Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, Divorced (or) (Usual place of abode)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 20-1920

7-AGE, 7 yrs. 7 mos. 14 da. If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School kid (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer.

9-BIRTHPLACE (city or town, State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (city or town, State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (city or town, State or Country)

14- (Informant) Nora Randall

(Address) 216 Otterheim St.

15- Filed 1921

Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-12-28

17- I HEREBY CERTIFY, That I attended deceased from 5-5-28 to 5-12-28

that I last saw him alive on 5-12-28

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bacterial Endocarditis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. G. Coyle, M. D.

19 (Address) 301 W. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, 5/14/28

20-UNDERTAKER, ADDRESS 84 W

932  
33873

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113E 33873

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Cecil

(a) RESIDENCE NO. 1002 N. Chester ST.,

WARD N. 2 N. IV

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 4/21/28

AGE Years Months Days 2 If LESS than 1 day, hrs. or min. 2 weeks

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Ind (State or country)

10 NAME OF FATHER John Keilen

11 BIRTHPLACE OF FATHER (city or town) Ind (State or country)

12 MAIDEN NAME OF MOTHER Birka Hillman

13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 11

W. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12-1928

17

I HEREBY CERTIFY, That I attended deceased from May 9, 1928, to May 12, 1928.

that I last saw him alive on May 12, 1928.

and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH\* was as follows:

Pre-maturity

(duration) yrs. mos. ds.

CONTRIBUTORY Acute Gastro-intestinal Ulsar (Secondary)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Godwin M. D.

5/13, 1928 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Oak Hill Cemetery  
August Pasch

May 14, 1928  
2408  
Ashland  
ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33874

## CERTIFICATE OF DEATH.

E 33874

1-PLACE OF DEATH

St. Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Mrs Elizabeth Albers

(a) RESIDENCE NO.

1418 W. Pratt

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female

white

widow

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Casper J. Albers

DATE OF BIRTH (month, day, and year)

Oct 9 1850

AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min

70

7

4

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER

not given

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

"

"

12 MAIDEN NAME OF MOTHER

"

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

"

"

14

Informant  
(Address)(Son) John Albers  
1418 W. Pratt St.

15

Filed

19

HARRISON JONES, M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13 1928

17

I HEREBY CERTIFY, That I attended deceased from  
5-8 1928 to 5-13 1928.that I last saw him alive on 5-13 1928  
and that death occurred, on the date stated above, at 10<sup>45</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. 5 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

No

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical findings

(Signed)

James H. Zimmerman, M.D.  
51328 (Address) 1729 N. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Redeemer

5-17 1928

20 UNDERTAKER

ADDRESS

E. B. Harber 115 E. West St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33875

E 33875

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *12-50* Ward)2-FULL NAME *Herman R. Telle*(a) RESIDENCE NO. *310 E. 20th St* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*male white**married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Mary C Telle*

6 DATE OF BIRTH (month, day, and year)

*Nov 1 1855*

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min..*72**6**10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Barber*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Germany*

10 NAME OF FATHER

*Not known*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Not known*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant

(Address)

*Mrs Mary Telle*  
*310 E 20th St*

15 Filed

19

*HARRISON JONES, M*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/11/28*

17

I HEREBY CERTIFY, That I attended deceased from

*5/11/28*, 19\_\_\_\_, to *5/11/28*, 19\_\_\_\_,that I last saw him alive on *5/11/28*, 19\_\_\_\_,and that death occurred, on the date stated above, at *9:45* m.

The CAUSE OF DEATH\* was as follows:

*Arteriosclerotic Cardio-vascular Disease*(duration) *Indefinite* mos. da.

CONTRIBUTORY

(Secondary)

*Gangrene of 1st Foot*(duration) yrs. *5* mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*J. S. Winstead*, M. D.

19

(Address)

*Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Tranmer Cemetery**5/14/28*

20 UNDERTAKER

ADDRESS

*W. M. Ratson**2038 N. N. Ave.*

AY 14 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33876

## CERTIFICATE OF DEATH.

90 E 33876

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Proctor

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Smeykal

(a) RESIDENCE NO.

(Usual place of abode)

1120 Proctor

ST.

WARD

Length of residence in city or town where death occurred 67 yrs. 5 mos. 3

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Mary A. Smeykal

DATE OF BIRTH (month, day, and year) Dec 8, 1860

AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

67

5

3

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Western Md R.R.

BIRTHPLACE (city or town)  
(State or country)

Baltimore Md

10 NAME OF FATHER

Frank Smeykal

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Sweden

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Not Known

14

Informant  
(Address)Mrs Mary A. Smeykal  
1120 Proctor

15

Filed

MAY 14 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1928

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 11, 1928, to May 11, 1928.

that I last saw him alive on May 11, 1928

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH\* was as follows:

Cardiac Hypertrophy (Chronic)

(duration) Not definite

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj. D. Harrison M.D.

5/13/1928 (Address) 1216 W. Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery May 15, 1928

20 UNDERTAKER

ADDRESS

Edmund W. Conklin 824 E. Eager St





E 33878

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 E 33878  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 Miller St., 1724

## 2-FULL NAME Nellie Morda

(a) RESIDENCE NO. 537 Miller

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAY 14 1928

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 12 1928

17

I HEREBY CERTIFY, That I attended deceased from MAR 18 1928, to MAY 12 1928, that I last saw him alive on MAY 11 1928, and that death occurred, on the date stated above, at 4:45 A. M. The CAUSE OF DEATH\* was as follows:

Scurvy

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL CREMATION OR

DATE OF BURIAL

UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33879

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Light near Cromwell St. St. 4 Ward 4)

2-FULL NAME Charles Blackwell.)C)

(a) RESIDENCE NO. 404 McWechen St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. -----

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. d.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
-------	-----------------	--

Male	Colored	Married
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9
10	10	10
11	11	11
12	12	12
13	13	13
14	14	14
15	15	15
16	16	16
17	17	17
18	18	18
19	19	19
20	20	20
21	21	21
22	22	22
23	23	23
24	24	24
25	25	25
26	26	26
27	27	27
28	28	28
29	29	29
30	30	30
31	31	31
32	32	32
33	33	33
34	34	34
35	35	35
36	36	36
37	37	37
38	38	38
39	39	39
40	40	40
41	41	41
42	42	42
43	43	43
44	44	44
45	45	45
46	46	46
47	47	47
48	48	48
49	49	49
50	50	50
51	51	51
52	52	52
53	53	53
54	54	54
55	55	55
56	56	56
57	57	57
58	58	58
59	59	59
60	60	60
61	61	61
62	62	62
63	63	63
64	64	64
65	65	65
66	66	66
67	67	67
68	68	68
69	69	69
70	70	70
71	71	71
72	72	72
73	73	73
74	74	74
75	75	75
76	76	76
77	77	77
78	78	78
79	79	79
80	80	80
81	81	81
82	82	82
83	83	83
84	84	84
85	85	85
86	86	86
87	87	87
88	88	88
89	89	89
90	90	90
91	91	91
92	92	92
93	93	93
94	94	94
95	95	95
96	96	96
97	97	97
98	98	98
99	99	99
100	100	100

5a If married, ~~XXXXXXXXXXXX~~  
HUSBAND of  
~~XXXXXXXXXX~~ Date:

Bettie Blackwell.(C)

8 DATE OF BIRTH (month, day, and year)  
July 1, 1870

7 AGE	Years	Months	Days 9	IF LESS than 1 day.....hrs. or.....min.
	57	10	8	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... **Laborer.**

(b) General nature of industry, business, or establishment in which employed (or employer)..... **N. Md. T. R. Co.**

(c) Name of employer

9 BIRTHPLACE (city or town).....  
(State or country) **Virginia.**

10 NAME OF FATHER Hiram Blackwell (

11 BIRTHPLACE OF FATHER (city or town).....  
(State or country) **Virginia.**

12 MAIDEN NAME OF MOTHER Rachael -----(C

13 BIRTHPLACE OF MOTHER (city or town).....  
(State or country) **Virginia.**

14 Informant Bessie Blackwell. (C) wife.  
(Address) 404 McMechen St.

15 Filed..... 19 ~~1928~~ ~~1929~~ Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1928

17 I HEREBY CERTIFY, That I took charge of the  
remains described above, held an **inquiry**  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....  
*inquiry*.....and that said deceased came to *his* death  
 (post mortem or autopsy or inquiry.)  
 on the day stated above.

The CAUSE OF DEATH\* was as follows:

**Myocardial Insufficiency.**  
Acute dilatation of the heart

(duration) .....yrs. ....mos. ....ds.

**CONTRIBUTORY**  
(Secondary)

(duration) ..... yrs. .... mos. .... ds.  
(Signed) *Wm. H. Stinson* M. D.  
(Coroner)

5/14 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

**IS LENGTH OF RESIDENCE** (For Hospitals, Institutions, Trans-  
lents, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.

19	PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial

Int Zion Cemetery	May 14 1928
20 UNDERTAKER	ADDRESS
Thomas E Nelson	1303 Hegeman St

ADDRESS

33880

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33880

## CERTIFICATE OF DEATH.

75-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3621 Fairview Ave 15-6 WARD)2-FULL NAME Sarah A Wilson(a) RESIDENCE NO. 3621 Fairview Ave ST. WARDLength of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 10 1858AGE Years 70 Months 4 Days 1 If LESS than 1 day, hrs or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) MD10 NAME OF FATHER Henry W. Eastman11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) MD12 MAIDEN NAME OF MOTHER Anna May Wentz13 BIRTHPLACE OF MOTHER (city or town) Fredrick (State or country) MD14 Informant Ida Eastman Levin (Address) 3621 Fairview Ave15 Filed 1-14-1928 19 HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1928

17

I HEREBY CERTIFY, That I attended deceased from Jan 7, 1928, to 5-11, 1928, that I last saw her alive on 5/11, 1928, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. E. Chapman, M. D.12, 1928 (Address) 2506 Harrison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn

DATE OF BURIAL

May 14 1928

20 UNDERTAKER

George J. SmithADDRESS 1532Hollen

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33881

## CERTIFICATE OF DEATH.

E 33881  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 5-8 Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 3116 Central Ave

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single6a If married, widowed, or divorced HUSBAND of (or) WIFE of None6 DATE OF BIRTH (month, day, and year) May 10 18847 AGE 43 Years Months Days 2 IF LESS than 1 day...hrs. or...min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Greece10 NAME OF FATHER Wm. L. L.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Greece12 MAIDEN NAME OF MOTHER Wm. L. L.

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Greece

PARENTS

14

Informant (Address) Pearl Thompson  
826 Somerset St.

15

Filed 1928

HARRISON JONES, JR.

R. H. H.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 192817 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.)thereon and from the evidence obtained by said Inquest, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia(duration) 7 yrs. 2 mos. 2 ds.CONTRIBUTORY (Secondary) Cholera(duration) 3 yrs. 1 mos. 1 ds.(Signed) Wm. L. L. (Coroner) 143 W. 1st St.19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Date of Burial May 15 1928

\*State the Illness Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death...yrs.,...mos.,...ds. In the State...yrs.,...mos.,...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Date of Burial May 15 192820 UNDERTAKER Ms Ida Sawden ADDRESS Madison St



E 33882

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

47 E 33882

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 E. Balt St. 1-3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME DA. Serebo FSKY

(a) RESIDENCE NO. 2231 E. Baltimore St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth 20 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE 54 Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant

(Address)

Filed

14 1928

H. A. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13/28

17

I HEREBY CERTIFY, That I attended deceased from May 27, 1927, to May 13, 1928.

that I last saw him alive on May 12, 1928.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

General Cancerous beginning in right breast.

(duration) 1 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1927

Was there an autopsy? no

What test confirmed diagnosis? operation volume

(Signed) A. J. Reis, M. D.

May 14, 1928 (Address) 24 St. Mary

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

North Bend &amp; Remond 5/14/28

Jach Lewis 1439 E. Baltimore St.

E 33883

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33883

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Eye, Ear & Throat Hosp. 3-4*)

## 2-FULL NAME

(a) RESIDENCE NO. *235 S. Eden St.*

(Usual place of abode)

Length of residence in city or town where death occurred *28* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 Color or Race

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Bessie Rahinowitz*

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years *45*Months *—*Days *—*

IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Robt. & Schechter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## PARENTS

14 Informant (Address) *Bessie Rahinowitz 235 S. Eden St.*15 Filed....., 19 *25*Registrar *REH*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17

I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*Ac Myocarditis*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

\*State the disease causing death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Wheeler Washington Rd 5/14/28*

## 20 UNDERTAKER

*Jack Lewis 439 E. 18th St*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33884

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 Duval Hill Ave ST. 13-59 WARD)

2-FULL NAME Gene E Brown

(a) RESIDENCE. No. 2412 Duval Hill Ave ST. 13-59 WARD.

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Cauc 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) May 9th 28

7 AGE Years Months Days 5 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) Baltimore

10 NAME OF FATHER James Brown

11 BIRTHPLACE OF FATHER (city or town, State or country) Baltimore

12 MAIDEN NAME OF MOTHER Bessie Brown

13 BIRTHPLACE OF MOTHER (city or town, State or country) Baltimore

14 Informant (Address) Bessie Brown 2412 Duval Hill Ave

15 Filed 1928 19 11 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 19 28

17 I HEREBY CERTIFY That I attended deceased from May 8, 1928, to May 13, 1928, that I last saw her alive on May 12, 1928, and that death occurred, on the date stated above, at 4:45 p. m.

The CAUSE OF DEATH\* was as follows:  
Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Cullen M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

771 - Ocean May 14 1928

20 UNDERTAKER ADDRESS

Sam. T. C. Grace 1400 N. 1st St.

# Caroline J. Caldwell HEALTH DEPARTMENT—CITY OF BALTIMORE

33885

## CERTIFICATE OF DEATH.

90 E 33885

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4200 Diller Ave. ST. 27-41 WARD)

2-FULL NAME Caroline J. Caldwell

(a) RESIDENCE NO. 4200 Diller Ave.  
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of John P. Caldwell (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9, 1849

7 AGE Years 78 Months 11 Days 2 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER John Koster

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Caroline Haubert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Miss Carrie P. Caldwell (Address) 2913 Riggs Avenue

15 Filed MAY 14 1928 REGISTRAR

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 19 26

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 19 26, to May 11, 19 26, that I last saw her alive on May 1, 19 26, and that death occurred, on the date stated above, at 10.15 A. M.

The CAUSE OF DEATH\* was as follows:

Cardiac Decomposition

(duration) yrs. mos. ds.

CONTRIBUTORY Art. Sclerosis (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles J. Jones, M. D.

Address 4706 Harford Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Loudon Park Cemetery

May 14 1926

## UNDERTAKER

ADDRESS

1033 West Baltimore St



E 33886

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33886

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *W. Dulles Gen Hwy 670* St., *670* Ward)2-FULL NAME *Max Kahn*(a) RESIDENCE No. *124 N. Milton R* St. *670* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Ida Kahn*6 DATE OF BIRTH (month, day, and year) *1885*7 AGE Years *43* Months Days IF LESS than 1 day.....hrs. or.....min.8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work *Tailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Russia* (State or country)10 NAME OF FATHER *Ben Kahn*11 BIRTHPLACE OF FATHER (city or town) *Russia* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Russia* (State or country)14 Informant *Ida Kahn* (Address) *14 N. Milton R*15 Filed *14* 16 *HAROLD JONES, R. D.* Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13* 192*8*17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest* (Inquest, au-

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Fractured Skull*

CONTRIBUTORY (Secondary)

(duration) *10* yrs. *10* mos. *10* ds.

(Signed)

*May 14 1928* (Address)(Coroner) *Coroner*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Hehren Trsch* Date of Burial *5/10 1928*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Pratt*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33887

## CERTIFICATE OF DEATH

E 33887

1-PLACE OF DEATH

777a. Gen. Hosp

REGISTERED NO.

City of BALTIMORE: (No.

St. 70-71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

777a. Katherine Wischow

(a) RESIDENCE NO.

4041 Frederick Ave

St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs 1 mos.

(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? 40 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 14, 1861

7 AGE

Years

67

Months

3

Days

27

IF LESS than  
1 day.....hrs.  
or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

Justin Blackert

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Dorothy Meyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant  
(Address)

Hosp. Record

15 Filed

19

H. M. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

May 11, 1928

17

I HEREBY CERTIFY, That I attended deceased from

4-26, 1928, to 5-11, 1928,

that I last saw her alive on May 11, 1928,

and that death occurred, on the date stated above, at 7:00 A. M.

The CAUSE OF DEATH\* was as follows:

Procidencia Uteri

CONTRIBUTORY  
(Secondary)

About 20 yrs

(duration) yrs. mos. ds.

Infant of lung

(duration) yrs. mos. ds.

18 Where was disease contracted

Home

if not at place of death?

Did an operation precede death? Yes Date of 4-30-28

Was there an autopsy?

What test confirmed diagnosis? Evidence

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

J. B. W. 850 W. Calver

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33888

## CERTIFICATE OF DEATH

123 E 33888

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Met Ym High 50-71*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Amelia Aarup*(a) RESIDENCE NO. *4501 Frederick Ave*

(Usual place of abode)

St. *Frederick* WardLength of residence in city or town where death occurred *14* yrs. *10* mos. *7* ds.(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 Color or Race *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *✓*6 DATE OF BIRTH (month, day, and year) *July 4 1853*

7 AGE

Years *74*Months *10*Days *7*IF LESS than  
1 day. hrs.  
or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *H. W. 37*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto*(State or country) *md.*10 NAME OF FATHER *Jacob Knief*11 BIRTHPLACE OF FATHER (City or town) *Germany*

(State or country)

12 MAIDEN NAME OF MOTHER *Rebecca Knief*13 BIRTHPLACE OF MOTHER (city or town) *Germany*

(State or country)

14

Informant  
(Address) *Hospital Records*15 Filed *1928*

19

17 J. A. JONES, JR.

Registrar *Blay*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11 1928*

19

17

I HEREBY CERTIFY, That I attended deceased from

*May 5 1928*, to *May 11 1928*that I last saw her alive on *May 11 1928*and that death occurred, on the date stated above, at *11:15 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute cholelithiasis  
choledochitis*(duration) *4* yrs. mos. ds.CONTRIBUTORY *Cardiac decompensation*

(Secondary)

*had been max decompensated heart*  
(duration) yrs. mos. *2* ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *Yes* Date of *5-9-28*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Dr. J. P. Jones, M. D.*

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Woodlawn Cemetery**May 15 1928*

20 UNDERTAKER

ADDRESS

*John R. Denny**715 Light St*

E 33889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 33889

1-PLACE OF DEATH *St. Agnes Hospital*

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Girl Scrimger*

(a) RESIDENCE NO. *14th & Frances Ave* ST. *Halethorpe Md* WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) \_\_\_\_\_

a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

DATE OF BIRTH (month, day, and year) *5-12-28*

AGE Years, \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs \_\_\_\_\_ or, \_\_\_\_\_ min *a few minutes*

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) *Balto.* (State or country) \_\_\_\_\_

10 NAME OF FATHER *James O Scrimger*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore Md* (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER *Sarah M Jeppio*

13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country) \_\_\_\_\_

14 Informant *James O Scrimger (Father)* (Address) *14th & Frances Ave Halethorpe Md*

15 Filed *14 1928* HAWKINS, JONES, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-12* 19 *28*

17 I HEREBY CERTIFY, That I attended deceased from *5-12*, 19 *28*, to *5-12*, 19 *28*.

that I last saw him alive on *5-12*, 19 *28*

and that death occurred, on the date stated above, at *2:30* p. m.

The CAUSE OF DEATH\* was as follows:

*Asphyxia neonatorum*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) *F. L. Redayliacca*, M. D.

, 19 \_\_\_\_\_ (Address) *St Agnes' Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *London Park*

DATE OF BURIAL

*May 14, 28*

20 UNDERTAKER

*John H. Denny*

ADDRESS

*715 Light*



E 33890

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33890

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Aliceanna ST. 2-4 WARD)2—FULL NAME Ernest T. Schlutter(a) RESIDENCE NO. 1715 Aliceanna ST. 2 WARDLength of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) WidowerIf married, widowed, or divorced  
HUSBAND of the late Ida Schlutter  
(or) WIFE ofDATE OF BIRTH (month, day, and year) 1871AGE 57 Years Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Germany  
(State or country)10 NAME OF FATHER Not Known11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)Informant Jones Whitehurst  
(Address) 1715 Aliceanna St.Filed 14 1928 19 HAROLD JONES, JR. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 192817 I HEREBY CERTIFY, That I attended deceased from 3/28, 1928, to 5/12, 1928, that I last saw him alive on 5/12, 1928and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH\* was as follows:

Tubercular Paralysis, Arteriosclerosis, Acute ScurvyCONTRIBUTORY Broken Heart (duration) yrs. 37 mos. ds.  
(Secondary) Heart Failure (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Serum & Symp. tests(Signed) W. A. Whitehurst M. D.5/14, 1928 (Address) 16238 North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Carmel Cemetery DATE OF BURIAL May 14 192820 UNDERTAKER Lilly & Zeller Inc. ADDRESS 403 S. Wolfe St.

See Letter in file dated May 16-1928 from  
HEALTH DEPARTMENT-CITY OF BALTIMORE

E 33891

CERTIFICATE OF DEATH.

10-0 E 33891

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *713* WARD)

2-FULL NAME *Aurelia S. Shackelford Johnson*

(a) RESIDENCE NO. *1613 Walker* ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) *June 25, 1922*  
AGE Years *5* Months *10* Days *18* If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*

10 NAME OF FATHER *Philip Shackelford*

11 BIRTHPLACE OF FATHER (city or town) *Va.* (State or country)

12 MAIDEN NAME OF MOTHER *Gladys Johnson*

13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)

14 Informant *Philip S. Shackelford* (Address) *1613 Walker St.*

15 Filed *G. HAMMOND JONES, M.D.* Registrar

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13, 1928*

17 I HEREBY CERTIFY, That I attended deceased from *May 13, 1928* to *May 13, 1928*, that I last saw her alive on *May 13, 1928*, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:  
*Diphtheria - Nosed, Tracheal & Pharyngeal*

(duration) yrs. mos. ds. CONTRIBUTORY *Acute cardiac dilatation* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *At home*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Bacteriological* (Signed) *Dr. J. L. Levin*, M. D.

5-13, 1928 (Address) *Sydenham Hospital*  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

*McCracken* DATE OF BURIAL *May 14, 1928*

20 UNDERTAKER *Robert Williams 1515 McElderry St.* ADDRESS

E 33892

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33892

## CERTIFICATE OF DEATH.

101-001

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 N. Green St. 17-25 WARD)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Lifes yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than  
1 day hrs.  
or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13- 1928

17

I HEREBY CERTIFY, That I attended deceased from May 7- 1928, to May 13, 1928, that I last saw him live on May 12, 1928, and that death occurred, on the date stated above, at 4 a in

The CAUSE OF DEATH\* was as follows:

Pneumonia, lobes

(duration) yrs. mos 6 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By ex. annals  
(Signed) T. W. Paul, M. D.

5-13-28 (Address) 1300 St Paul

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

New Cath. Cem.

5/14/28

George J. Paul

1735 Hager

E 33893

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33893

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 N. Paterson Park <sup>12</sup> WARD)

2-FULL NAME Joshua T. Hopkins

(a) RESIDENCE No. 1235 N. Paterson Park <sup>12</sup> WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single Married Widowed, or Divorced (write the word)

Male White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Virginia Hopkins

6 DATE OF BIRTH (month, day, and year) May 11, 1844

7 AGE Years Months Days If LESS than 1 day, hrs. or min

84

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Retired

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1928

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1928, to May 10, 1928, that I last saw him alive on May 10, 1928

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Senile Dementia

CONTRIBUTORY (Secondary) Chronic Endocarditis (duration) 1 yrs. mos. ds.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Rogers, M.D.

May 10, 1928 (Address) 1305 N. Paterson Park

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeem Church May 1928

20 UNDERTAKER

ADDRESS

George F. Ruth 1735 Hayfield



E 33894 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3409 Grantley Road, 15-62 ST. WARD)

2-FULL NAME

(a) RESIDENCE NO. 3409 Grantley Road, ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX 2 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm W. Baker

DATE OF BIRTH (month, day, and year) 7/16/1879

AGE Years 48 Months 5 Days 27 If LESS than 1 day, hrs or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Philip M. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13/28

17

I HEREBY CERTIFY, That I attended deceased from

March 15, 1927, to May 13, 1928.

that I last saw her alive on May 12, 1928.

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. B. Williams, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33895

## CERTIFICATE OF DEATH.

E 33895

1-PLACE OF DEATH

4419

Cradock Ave

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Francis A. Jones

(a) RESIDENCE NO.

4419

Cradock Ave

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

58

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

John H. Jones

6 DATE OF BIRTH (month, day, and year)

1-1-18

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

71

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Quincy Ann Co. Ind

10 NAME OF FATHER

Perry Daniels

11 BIRTHPLACE OF FATHER (city or town)

Ind

(State or country) /

12 MAIDEN NAME OF MOTHER

Nancy Tarrell

13 BIRTHPLACE OF MOTHER (city or town)

Ind

(State or country)

14

Informant  
(Address)John Jones Jr.  
4419 Cradock Ave

15

FILED

H. JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-12-18

17

I HEREBY CERTIFY, That I attended deceased from

4-14-18, 19 to 5-12-18, 19

that I last saw him alive on 5-11-18, 19

and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH\* was as follows:

Apoplexy  
with myocarditis  
and chronic dilatation  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? M

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

19 (Address) 4217 Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Calvary Cem.

5/14 1928

20 UNDERTAKER

ADDRESS

Byron Wright 1218 Mc Elderry

33896

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

154 E 33896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 E. Lexington ST., 5-8 WARD)

2-FULL NAME Sarah Edna Cook Sewell

(a) RESIDENCE NO. 1318 E. Lexington ST., WARD

Length of residence in city or town where death occurred Life mos. da. How long in U. S. if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX 7 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Sewell

DATE OF BIRTH (month, day, and year) May 5, 1907

AGE Years 21 Months 0 Days 6 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER James H. Cook

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Letta Inguice

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

Informant J. H. Cook (Address) 1318 E. Lexington

Filed C. H. JONES, M. D. Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1928

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1928, to May 11, 1928, that I last saw her alive on May 10, 1928, and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis - Ulcerated

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Test of heart

(Signed) W. S. Berry, M. D.

19 (Address) 1420 E. Chase

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER Hall Chapp. Solley & Co. 1111 N. Main

DATE OF BURIAL

May 16 1928

ADDRESS

1111 N. Main

E 33897

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33897

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 11.B. WARD 31)2. FULL NAME Jack Paluska(a) RESIDENCE No. None  
(Usual place of abode)Length of residence in city or town where death occurred Unknown mos.ST. 11.B. WARD 31

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth Unknown yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Singlea If married, widowed, or divorced  
HUSBAND of  
or WIFE ofDATE OF BIRTH (month, day, and year) 1886AGE Years 42 Months Days If LESS than 1 day, hrs. or min.

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer UnknownBIRTHPLACE (city or town) (State or country) Poland10 NAME OF FATHER Tom Paluska11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia14 Informant (Address) Hospital Records15 Filed 4-19-28 19 C. HAMPTON JONES, M. D. Registrar W. R. H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 192817 I HEREBY CERTIFY, That I attended deceased from May 7, 1928 to May 14, 1928that I last saw him alive on May 14, 1928and that death occurred, on the date stated above, at 4.40 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical & laboratory  
(Signed) [Signature] M. D.5-14-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

Buried Heart

DATE OF BURIAL

5.14 1928

20 UNDERTAKER

J. J. Tobey & Son

ADDRESS

1318 Light St.



HEALTH DEPARTMENT—CITY OF BALTIMORE **E 33898**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. **901 St Paul**ST. **11-15** WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

**Ellen Carter Howard**

(a) RESIDENCE NO.

**901 St Paul**

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred **29** yrs. **10** mos. **26** ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 Single, Married, Widowed, or Divorced, (write the word) **Married**

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

**Charles Mott Howard**

6 DATE OF BIRTH (month, day, and year)

**March 3, 1867**

7 AGE

**61**

Years

**2**

Months

**89**

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

**None**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

**Philadelphia, Pa.**

10 NAME OF FATHER

**Charles Carter**

11 BIRTHPLACE OF FATHER (city or town) (State or country)

**Virginia**

12 MAIDEN NAME OF MOTHER

**Ellen Newman**

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

**Phila, Pa**

14

Informant (Address)

**Charles Mott Howard 901 St Paul St Balto**

15

Filed

19

**C. HAMPTON JONES, M. D.**

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **May 12 1928**

17

I HEREBY CERTIFY, That I attended deceased from **May 10<sup>th</sup> 1928** to **May 12<sup>th</sup> 1928**, that I last saw her alive on **May 12<sup>th</sup> 1928**, and that death occurred, on the date stated above, at **3.50 P.m.**

The CAUSE OF DEATH\* was as follows:

**Coronary thrombosis**

CONTRIBUTORY (Secondary)

(duration) **2 hours** yrs. mos. ds.(duration) **3** yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

**E. M. Wan M.D.**

M. D.

**5.14, 1928 (Address) 1515 Park Ave**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

**GARRISON FORIST THOMAS****5-16 1928**

20 UNDERTAKER

CEM

ADDRESS

**H. W. JENKINS & SONS. Co. M. E. L. H. Co.**

E 33899

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31

E 33899

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals (T.B.) ST. 58 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Savage

(a) RESIDENCE No. 916 Fayette st.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos.

ST. 58 WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Separated

If married, widowed, or divorced HUSBAND of or WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1891 ?

AGE Years Months Days If LESS than 1 day, hrs. or min. 37 ?

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Ed Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Reat Laurence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address)

15 Filed 4-10-28 C. HAMPSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1928

17 I HEREBY CERTIFY, That I attended deceased from March 13, 19 28, to May 11, 19 28, that I last saw him alive on May 11, 19 28, and that death occurred, on the date stated above, at 8.50 p. m. The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY Tuberculous enteritis (Secondary)

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical & Laboratory

(Signed) L. M. Madden, M. D.

5-12-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner H. K. H.
MAY 14 1928

UNIVERSITY OF MARYLAND.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33900

## CERTIFICATE OF DEATH

E 33900

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *9*)

## 2-FULL NAME

(a) RESIDENCE NO. *500*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*male**white**Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 Filed

C. HAMILTON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from *5-6-28* 19*28*, to *5-12-28* 19*28*, that I last saw him alive on *5-12-28* 19*28*, and that death occurred, on the date stated above, at *6<sup>10</sup> p.* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of liver*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes*, Date of *5-7-28*Was there an autopsy? *Positive*What test confirmed diagnosis? *Clinical*

(Signed)

. 19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDER-SIGNER

ADDRESS

E 33901

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33901

## CERTIFICATE OF DEATH:

1. PLACE OF DEATH

Church Home &amp; Infirmary

CITY OF BALTIMORE: (No.

ST. 13-29 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Mark Newman (Mondawmin)

(a) RESIDENCE NO.

2329 Mondawmin Street

(Usual place of abode)

Length of residence in city or town where death occurred

7 yrs. 10 mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Fannie Newman

6 DATE OF BIRTH (month, day, and year)

April 10/1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

1

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Warsaw Poland

10 NAME OF FATHER

David Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Warsaw Poland

12 MAIDEN NAME OF MOTHER

Fannie Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Warsaw Poland

14

Informant (Address)

Fannie Newman 3405 Mondawmin Ave

15

Filed

C. H. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-14-1928

17

I HEREBY CERTIFY, That I attended deceased from 5-8-1929 to 5-14-1928.

that I last saw him alive on

5-14-1928

and that death occurred, on the date stated above, at

1029 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Rectum (with generalized carcinomatous)

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Myocardial Failure

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of 5-11-28

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. Hammond Jones, M. D.

19

(Address)

Church Home &amp; Infirmary

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery

May 15, 1928

20 UNDERTAKER

J. Ahern &amp; Co.

ADDRESS

2432 Quarters Lane Rd



*Hartman*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

33902

## CERTIFICATE OF DEATH.

74 E 33902

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

607 E. 33rd

ST., 9-46 WARD)

## 2-FULL NAME

Elizabeth T. Hartman

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

607 E. 33rd

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

72 yrs. 5 mos. 26 ds.

How long in U. S., if of foreign birth?

-- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Edward A. Hartman

6 DATE OF BIRTH (month, day, and year)

Nov. 14, 1855

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

72

5

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

Baltimore  
Maryland

PARENTS

10 NAME OF FATHER John B. Seidenstricker

11 BIRTHPLACE OF FATHER (city or town; State or country)

Baltimore  
Maryland

12 MAIDEN NAME OF MOTHER Hannah Cragg

13 BIRTHPLACE OF MOTHER (city or town; State or country)

Baltimore  
Maryland

14

Informant  
(Address)John A. Hartman  
612 W. University Parkway

15

Filed

19

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 12 1928

17

I HEREBY CERTIFY, That I attended deceased from

May 7, 1928, to May 12, 1928.

that I last saw him alive on

May 12, 1928.

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration)

yrs.

mos

3

ds

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

R. G. Davis

M. D.

May 14, 1928

(Address) 1509 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Loudon Park Cemetery

5/15 1928

20 UNDERTAKER

ADDRESS

Henry U. Mears &amp; Son 80.57 Calvert

33903

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33903

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Wm 1 Hope Return* 28-63)ST. *28-63* WARD2. FULL NAME *Thomas B. Arnold*(a) RESIDENCE NO. *Wm 1 Hope Return*

(Usual place of abode)

ST.

WARD *Washington D.C.*Length of residence in city or town where death occurred *2* yrs. *9* mos. - ds.How long in U. S. if of foreign birth? *73* yrs. - mos. - ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *none*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*73**unknown*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Washington D.C.*10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *unknown*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *unknown*

14

Informant (Address) *Wm 1 Hope Return*

15

Filed

19

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 14 1928*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 15*, 1925, to *May 14*, 1928, that I last saw him alive on *May 14*, 1928, and that death occurred, on the date stated above, at *12:15* noon m.

The CAUSE OF DEATH\* was as follows:

*Chr. Endocarditis (Valvular Insufficiency) (Cardiac Arrhythmia)**unknown*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Parasitic Infection*

(duration) 30 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *no*

Date of

Was there an autopsy? *no*What test confirmed diagnosis? *Physical*(Signed) *Hulton P. Hill*

M. D.

19 (Address) *Wm 1 Hope Return*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Washington D.C.**May 14 1928*

20 UNDERTAKER

ADDRESS

*Stewart & Son**Belle*

**E 33904**

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**E 33904**

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 402 N Lakewood Ave 10 Ward)2-FULL NAME John W. Becker(a) RESIDENCE NO. 402 N Lakewood St ave WardLength of residence in city or town where death occurred 25 yrs. 6 mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27-19027 AGE Years 25 Months 6 Days 15 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER Conrad Becker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Berttrude Meador

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14 Informant (Address) Augusta Becker  
402 N Lakewood

15 Filed

16

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 19 28

17

I, HEREBY CERTIFY, That I attended deceased from Mar 29 19 28, to May 12 19 28,that I last saw him alive on May 12 19 28,and that death occurred, on the date stated above, at 402 m.

The CAUSE OF DEATH\* was as follows:

Septic Infection(duration) yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Meyer, Jr.M. D. 2. 19 28 (Address) 1500 E 33rd St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER

ADDRESS

Monmouth Cem May 15 19 28  
John C. Miller 2435 E Oliver  
St

33905

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33905

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Fred Stone

### (a) RESIDENCE No.

1614 Gough

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds.

How long in U. S. if of foreign birth? 12 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

divorced

6a If married, widowed, or divorced HUSBAND of or WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

46

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

Amos Stone

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pennsylvania

14

Informant

(Address)

Records

15

Filed

19

ATK

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12/1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 31, 1923, to May 12, 1928

that I last saw him live on May 12, 1928

and that death occurred, on the date stated above, at 3:40 P. M.

The CAUSE OF DEATH\* was as follows:

myocardial infarction  
mesenteric thrombosis  
peritonitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? General & Sub

(Signed) C. Volante Boyd M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Baltimore, in May 15, 1928

20 UNDERTAKER

ADDRESS

John C. Miller 2435 E. Calver



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33906

## CERTIFICATE OF DEATH.

90 E 33906

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1609 N Montford St. 8-16 Ward)2-FULL NAME Ella S. Merryman(a) RESIDENCE NO. 1609 N Montford Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)Female WhiteWidowed6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 1853

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.751

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Housewife

9 BIRTHPLACE (city or town)

(State or country)

Balto Md

10 NAME OF FATHER

John Merryman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto Md

14

Informant  
(Address)Margaret Stone  
1609 N Montford Ave

15 Filed

19

1928 C. H. HARRISON Jones, N. D.  
RPH Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

May 13 1928

17

I HEREBY CERTIFY, That I attended deceased from

Jan 3, 1928, to May 13, 1928,that I last saw her alive on May 13, 1928,and that death occurred, on the date stated above, at 4:55 p.m.

The CAUSE OF DEATH\* was as follows:

Mitral murmur acute  
Enteritis Bronchitis(duration) ..... yrs. 4 1/2 mos. .... ds.

CONTRIBUTORY

(Secondary)

of age(duration) small yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of.....Was there an autopsy? noWhat test confirmed diagnosis? Clinical

(Signed)

R. P. Carman M. D.5-13-1928 (Address) 1707 N. Caroline St.\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

Western Cem May 16 1928

20 UNDERTAKER

ADDRESS

John C. Miller 2435 E. Calver25

E 33907

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 33907

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day... hrs. or... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That attended deceased from May 13, 1928, to May 13, 1928, that I last saw h<sup>e</sup> alive on May 13, 1928, and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* as follows:

Acute Cordiac Dilatation

CONTRIBUTORY (Secondary)

Chronic Myocarditis

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

. 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificates.

E 33908

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33908

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

University Hospital ST. 24-34 WARD)

## 2-FULL NAME

Margaret C. Simmons

(a) RESIDENCE NO.

1725 Covington ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

John W. Simmons

6 DATE OF BIRTH (month, day, and year)

Thylen 1888

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

40

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

House wife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER

Joseph J. Oniel

PARENTS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Annie Myers

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore, Md.

14

Informant  
(Address)

Hospital record

15

Filed 1928

C. HAMPSON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/12/28

17

I HEREBY CERTIFY, That I attended deceased from

4/30/28, 19, to 5/12/28, 19,

that I last saw him alive on 5/12/28, 19,

and that death occurred, on the date stated above, at 11:35 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

Scirvie Elds Vazant, M. D.

, 19 (Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

2 Cedar Hill Cem. May 13, 1928

ADDRESS

UNDERTAKER

C. H. Evans &amp; Son

# HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33909

## CERTIFICATE OF DEATH.

31 E 33909

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals (T.B.) ST. 11-27 WARD 31)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Fitzpatrick

(a) RESIDENCE No. 1520 W. Pratt st. ST. Life WARD Life

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Francis Fitzpatrick

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE Years 50 Months 0 Days 0 If LESS than 1 day, hrs. 0 or, min. 0

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Patrick Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Katherine

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Hospital Recores (Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1928

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 19 27, to May 12, 19 28, that I last saw him alive on May 12, 19 28, and that death occurred, on the date stated above, at 12.50 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) unknown ds. CONTRIBUTORY Tuberculous Enteritis (Secondary) (duration) unknown ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab. X-Ray Clinical (Signed) L. J. Madden, M. D.

5-12-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-  
Holy Cross Cem

DATE OF BURIAL

5/15 1928

20 UNDERTAKER

Robert Brooks & Son

ADDRESS

Cathlam Hollin st



HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33910

CERTIFICATE OF DEATH

E 33910

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3011 Grayson ST.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Long

(a) RESIDENCE NO. Emmitsburg Md ST., WARD

Length of residence in city or town where death occurred - yrs. - mos. 14 ds.

How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widower

If married, widowed, or divorced

HUSBAND of (or) WIFE of Adelaide Weirick Long

DATE OF BIRTH (month, day, and year) Oct 20 1872

AGE Years 75 Months 6 Days 24 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Emmitsburg Md (State or country)

10 NAME OF FATHER Jacob A Long

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Catherine Sproul

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

Informant Mrs Charles Long (Address) 3011 Grayson St

Filed 15 1928

HAMMON JONES, M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1928

17 I HEREBY CERTIFY, That I attended deceased from May 7 1928, to May 14 1928 that I last saw him alive on May 14 1928 and that death occurred, on the date stated above, at 11:14 Pm.

The CAUSE OF DEATH\* was as follows:

Emphysema Acute Cardiac Dehilitation

CONTRIBUTORY (Secondary) Indefinite (duration) yrs. mos. ds. Pulmonary Edema

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

(Address) 2601 Western Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Emmitsburg Md

May 15 1928

20 UNDERTAKER

ADDRESS

M. F. Shufflen Emmitsburg Md

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33911

## CERTIFICATE OF DEATH

74-001 E 33911  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *10-10* St. *6-10* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *2416 E Baltimore St.*

(Usual place of abode)

Ward

Length of residence in city or town where death occurred *yr. mos. ds.*(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? *yr. mos. ds.*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Rose Palitz*

6 DATE OF BIRTH (month, day, and year)

*Mar. 24 1882*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or min..*46**1**19*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Confectioner**019*

9 BIRTHPLACE (city or town)

(State or country)

*Greece*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Greece*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Greece*

14

Informant  
(Address)*Rose Palitz,  
2416 E. Balt. St.*

15 Filed

*15-1926**10-10*

Registrar

*Relig*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*5/13 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*5/13 1928*, to*5/13 1928*

that I last saw h. alive on

*5/13 1928*

and that death occurred, on the date stated above, at

*10:20 P.M.*

The CAUSE OF DEATH was as follows:

*Cerebral Hemorrhage*

CONTRIBUTORY

(Secondary)

(duration) *Unknown* yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*At home*

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Clinical signs*

(Signed)

*C. C. Jones*, M. D.

, 19

(Address)

*1012 E. Baltimore St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Holy Cross A. A. C. May 16 1928*

20 UNDERTAKER

ADDRESS

*Margaret G. Flynn 1422 Light*

very important. See instructions on back of certificate.

*Mary A. Peterson*

**E 33912 HEALTH DEPARTMENT—CITY OF BALTIMORE E 33912**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2546 W. Baltimore ST. 70-69 WARD)2-FULL NAME Mary A. Peterson(a) RESIDENCE NO. 2546 W. Baltimore St. ST. 70-69 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of Edward W. Peterson (or) WIFE of6 DATE OF BIRTH (month, day, and year) Dec. 30, 1851

7 AGE Years 76 Months 4 Days 13 If LESS than 1 day, hrs. 14 or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)10 NAME OF FATHER Arthur T. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant R. B. Bradshaw  
(Address) 2546 W. Baltimore St.

15 Filed 1928 11 REGISTRAR Joseph B. Cook

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 19 28

17 I HEREBY CERTIFY That I attended deceased from Nov. 15, 19 27, to May 13, 19 28.

that I last saw her alive on May 13, 19 28.and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis  
arterio sclerosis  
(duration) yrs. 6 mos. ds.

CONTRIBUTORY arterio sclerosis  
(Secondary) indeterminate yrs. 0 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? no

What test confirmed diagnosis? Clinical  
(Signed) W. B. Friedman, M.D.  
2/14 19 28 (Address) 632 Washington Blvd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Loudon Park CemeteryMay 15 19 28

20 UNDERTAKER

ADDRESS

100 West Baltimore St.

E 33913

Cecelia E. Durham  
HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33913

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 46 Gorman Avenue ST. 129-69 WARD)

2-FULL NAME Cecelia E. Durham

(a) RESIDENCE NO. 46 Gorman Avenue

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Franklin P. Durham

6 DATE OF BIRTH (month, day, and year) Nov. 10" 1857

7 AGE Years 70 Months 6 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

10 NAME OF FATHER Mr. Dobbins

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ross F. Durham (Address) 46 Gorman Ave.

15 MAY 15 1928 HANNAH JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 13" 1928

17 I HEREBY CERTIFY, That I attended deceased from Sept 1927 to May 13 1928 that I last saw her alive on May 12 1928 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) duration yrs. mos. ds. 1

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter C. Trichman, M. D.

5/14/28 (Address) 2002 Lexington Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Olivet Cemetery

UNDERTAKER

1928

1928

DATE OF BURIAL

May, 15" 1928

ADDRESS 1505 West Baltimore St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33914

## CERTIFICATE OF DEATH.

E 33914

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West. Bacto Pen. Hospital 68*)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Atta U. S. Pen. &amp; Prison

6 DATE OF BIRTH (month, day, and year)

Aug 6 1882

7 AGE

Years

Months

Days

If LESS than 1 day, has or min.

65

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Harry Feldman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Maggie Sternman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Josephine S. Sander

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 11 1928

17

I HEREBY CERTIFY, That I attended deceased from April 3, 1928, to May 11, 1928,

that I saw him alive on May 11, 1928,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Broken Rt. Femur

CONTRIBUTORY (Secondary) (duration) yrs. 1 mos. 10 ds. Cardiac Failure

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and X-Ray

(Signed) Paul Schenker, M. D.

, 19 (Address) West Bacto Pen. &amp; Prison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Sander Park

DATE OF BURIAL

May 13 1928

20 UNDERTAKER

Jonah Sykes 1600 N. North Ave

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33915

## CERTIFICATE OF DEATH.

91 E 33915

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. WARD)2-FULL NAME *John T. Croucher*(a) RESIDENCE NO. *Stemmer Run* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *68* yrs. *7* mos. *3* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *m*4 COLOR OR RACE *m*5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Elizabeth N. Croucher*6 DATE OF BIRTH (month, day, and year) *Oct. 11<sup>th</sup> 1859*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*68**7**3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Watchman B. & S. Co.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto. Md.*10 NAME OF FATHER *George Croucher*11 BIRTHPLACE OF FATHER (city or town) (State or country) *England*12 MAIDEN NAME OF MOTHER *Margt. Dwyer*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *Elizabeth N. Croucher*

15

Filed

1928

19

C. HANSON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 14 1928*

17

I HEREBY CERTIFY, That I attended deceased from *3-13*, 19 *28*, to *5-14*, 19 *28*.that I last saw him alive on *5-14*, 19 *28*and that death occurred, on the date stated above, at *140* m.

The CAUSE OF DEATH\* was as follows:

*arteriosclerosis  
gangrene with sepsis*(duration) *4* yrs. *4* mos. *4* ds.CONTRIBUTORY (Secondary) *Tuberculosis + Endocarditis*(duration) yrs. *4* mos. ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *J. Lawrence Palmer, M. D.*, 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Lilly-green Inc.**403 S. Wolfe St.*

## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 33916

## CERTIFICATE OF DEATH.

100 E 33916

1-PLACE OF DEATH

Sinner Hosp

CITY OF BALTIMORE: (No.

ST. 15th WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rita Sands

(a) RESIDENCE No.

2625 Hudson

(Usual place of abode)

Length of residence in city or town where death occurred

7 yrs.

mos.

ST. 1 WARD

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar. 28<sup>th</sup> 1927

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min

13

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md

10 NAME OF FATHER

James A. Sandt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md

12 MAIDEN NAME OF MOTHER

Ida R. Werslowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md

14

Informant (Address)

James A. Sandt Father  
2625 Hudson St.

15

Filed

19

C. HARRISON JONES, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/13 1928

17

I HEREBY CERTIFY, That I attended deceased from

4/25, 1928, to 5/13 1928

that I last saw her alive on

5/13 1928

and that death occurred, on the date stated above, at

8:30 p.m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia  
Emphysema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thoracentesis

(Signed) Meyer Miller, M.D.

(Address)

Sinner Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislaus Cemetery May 15<sup>th</sup> 1928

20 UNDERTAKER

Lilly &amp; Ziehl &amp; Co.

ADDRESS

432 Wolf St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33917

## CERTIFICATE OF DEATH.

74-001  
REGISTERED NO.

E 33917

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Little Sister of the Poor St.* 10-14 *Ward*)

## 2-FULL NAME

## (a) RESIDENCE NO.

Length of residence in city or town where death occurred *50* yrs.(If death occurred in a hospital or institution, give its NAME instead of street and number.)  
(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 Color or Race *N* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

8 DATE OF BIRTH (month, day, and year) *July 16* 18427 AGE *85* Years *86* Months *9* Days *28* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)

## 15 Filed

C. HAMBON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

17

I HEREBY CERTIFY, That I attended deceased from *May 1*, 1928, to *May 14*, 1928, that I last saw him alive on *May 14*, 1928, and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH\* was as follows:

*Senility*  
*Cerebral hemorrhage*  
(duration) ..... yrs. .... mos. *14* ds.

## CONTRIBUTORY

(Secondary)

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death?..... Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *D. Bernard Ross*, M. D.5/14/28 (Address) *914 E. Biddle St.*

\*State the Disease causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificates.



213 E 33918

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

37-2-28 E 33918  
REGISTERED NO.

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL)ST. 16-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

Charles Montgomery

## (a) RESIDENCE NO.

937 U - Street, St - WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 7 ds. How long in U. S. If foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word)a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1-7-28AGE Years Months Days If LESS than 1 day, hrs. or min.  
4 7

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

7 BIRTHPLACE (city or town) Ind -  
(State or country)10 NAME OF FATHER Genie Montgomery11 BIRTHPLACE OF FATHER (city or town) Ind -  
(State or country)12 MAIDEN NAME OF MOTHER Bertha Henry13 BIRTHPLACE OF MOTHER (city or town) Ind -  
(State or country)14 Informant Records -  
(Address)15 Filed 15 1928 HARVEY JONES Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 - 28

17

I HEREBY CERTIFY, That I attended deceased from May 6, 1928, to May 14, 1928, that I last saw him alive on May 14, 1928, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Miliary TuberculosisCONTRIBUTORY (Secondary) No (duration) yrs. mos. 14 ds.18 Where was disease contracted if not at place of death? at homeDid an operation precede death? No Date ofWas there an autopsy? yesWhat test confirmed diagnosis? autopsy(Signed) M. C. Goodwin, M. D.5-14, 1928 (Address) Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-  
MOVAL St. John's Church DATE OF BURIAL May 15 192820 UNDERTAKER Sam. H. Chase Son ADDRESS 1400 Mosher

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33919

## CERTIFICATE OF DEATH

129 E 33919

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 702 N. Caroline St. 10-13 Ward)2-FULL NAME Margaretha Zimmerman(a) RESIDENCE NO. 702 N. Caroline St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. - mos. 13 ds.How long in U. S. if of foreign birth 5 yrs. - mos. \_\_\_\_\_ ds. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Zimmerman6 DATE OF BIRTH (month, day, and year) May 1, 18557 AGE Years 73 Months \_\_\_\_\_ Days 13 IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

10 NAME OF FATHER Martin Mayer11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Anna Gaeffel13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Miss Anna M. Zimmerman  
(Address) 702 N. Caroline St

15 Filed \_\_\_\_\_, 19 \_\_\_\_\_ Registrar \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 19 2817 I HEREBY CERTIFY, That I attended deceased from May 9, 19 28, to May 14, 19 28that I last saw him alive on May 13, 19 28and that death occurred, on the date stated above, at 2:45 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
Chronic Hypertension  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.CONTRIBUTORY Arteriosclerosis  
(Secondary)  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.

18 Where was disease contracted \_\_\_\_\_

If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) J. S. Smith M. D.1918 (Address) 644 N. Madison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Holy Redeemer Cemetery May 16 19 28  
Henry Hock Son 1301 E. Bayview

very important. See instructions on back of certificates.

E 33920

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33920

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bow Secour Hospital* ST. *7-47* WARD)2. FULL NAME *Edith W. A. Brown*(a) RESIDENCE NO. *621 Spring Hill Terrace* ST. *7* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *26* yrs. *1* mos. *23* ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? *26* yrs. *1* mos. *23* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
~~HUSBAND~~ of *Martin G. Brown*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *March 21 1902*7 AGE Years *26* Months *1* Days *23* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife* *037*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md*  
(State or country)10 NAME OF FATHER *David Bryant*11 BIRTHPLACE OF FATHER (city or town) *Md*  
(State or country)12 MAIDEN NAME OF MOTHER *Miss Fisher*13 BIRTHPLACE OF MOTHER (city or town) *Md*  
(State or country)14 Informant *Mr. Martin G. Brown*  
(Address) *621 Spring Hill Terrace*15 Filed *15 1928* *W. J. JONES, M. D.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 14* 19 *28*I HEREBY CERTIFY, That I attended deceased from *Mar 16*, 19 *28*, to *May 14*, 19 *28*.that I last saw her alive on *May 14*, 19 *28*and that death occurred, on the date stated above, at *11:40* A. m.

The CAUSE OF DEATH\* was as follows:

*Malignant Endocarditis*(duration) yrs. *3* mos. ds.CONTRIBUTORY  
(Secondary) *same*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*  
(Signed) *George O. Eaton*, M. D.(Address) *Bow Secour Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*New Cathedral Cemetery* *May 18* 19 *28*20 UNDERTAKER *Henry Wood* ADDRESS *1301 E Bay St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33921

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2411 Maryland Ave) WARD 7-51

## 2-FULL NAME

(a) RESIDENCE No. 2411 Maryland Ave ST. Life WARD 7-51(Usual place of abode)  
Length of residence in city or town where death occurred

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

E 33921

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fe

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 3, 1880

7 AGE

Years

88

Months

-

Days

9

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

Maryland

10 NAME OF FATHER

Levi Rust

11 BIRTHPLACE OF FATHER (city or town; State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Mary Mittle

13 BIRTHPLACE OF MOTHER (city or town; State or country)

Balto Md

14

Informant (Address)

Althea Robinsons  
2411 Maryland Ave

15

Filed

13 1928

16

W. H. JONES, M. D.  
Plt

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 192817 I HEREBY CERTIFY That I attended deceased from Jan 28 to May 12 1928that I last saw him alive on May 11 1928and that death occurred, on the date stated above, at 940 a.m.

The CAUSE OF DEATH\* was as follows:

Influenza

(duration)

yrs.

mos.

4 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical Examination

(Signed)

W. H. JONES, M. D.  
14, 1928 (Address) 1822 W Baltimore St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

London ParkMay 15 1928George SmithHollins



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33922

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Lancaster ST. 2-4

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Pauline Strumpkowski

(a) RESIDENCE No.

1614 Lancaster ST.

WARD

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1928, to May 13, 1928, that I last saw her alive on May 13, 1928, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

33923

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33923

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

16

H. J. JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, and found that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Shock + Internal Hemorrhage at once. Run over by Truck. Thos. B. Horton, M. D. (Coroner) 1428 Curtis Bay, Md.

\*State the Disease Cause of Death, or a death from Violent Causes, state (1) Means and Nature of Injury, and (2) Accidental, Suicidal, or Homicidal.

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Western Cemetery May 15-1928.

20 UNDERTAKER

ADDRESS

Charles J. Schwab 6057 Monroe St.

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33924

## CERTIFICATE OF DEATH

E 33924

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 16-68 St. Ward)2-FULL NAME James Melvin Ford(a) RESIDENCE NO. 2530 Harlem ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 6, 19287 AGE Years 2 Months 4 Days 8 IF LESS than 1 day 8 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balta(State or country) Md.10 NAME OF FATHER Melvin Ford

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balta Md12 MAIDEN NAME OF MOTHER Ruth Robinson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balta Md14 Informant Walter Ford (Address) 2530 Harlem av15 Filed May 15 1928 16 Registrar James B. Jones

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/28 1917 I HEREBY CERTIFY, That I attended deceased from 4/26/28, 19, to 5/14/28, 19that I last saw him alive on 5/13/28, 19and that death occurred, on the date stated above, at 3:58 m.

The CAUSE OF DEATH\* was as follows:

Pyloric Stenosis(Location) congenital yrs. 0 mos. 0 ds.

## CONTRIBUTORY

(Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 4/28/28

Was there an autopsy?

What test confirmed diagnosis? operation(Signed) G. S. Winstead, M. D., 19 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Woods Lane cemMay 15 1928

20 UNDERTAKER

ADDRESS

James B. Tyres1324 Entaw

very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33925  
PLACE OF DEATH182 E 33925  
REGISTERED NO.

City of BALTIMORE: (No. Pier No. 8 Locust Point. St. 16-23 Ward)

2-FULL NAME Lucian Cofield.(C)

(a) RESIDENCE NO. 1209 W. Lanvale St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 Color or Race 5 Single, Married, Widowed, or Divorced, (write the word)

Male. Colored Married

5a If married, write name of HUSBAND of  
XXXXXXXXXX  
XXXXXXXXXX

Isabelle Cofield.

6 DATE OF BIRTH (month, day, and year)

Do not know.

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.  
29 -----

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Freight handler

(b) General nature of industry, business, or establishment in which employed (or employer)..... B. &amp; O. R. R. Co.

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Missouri.

## 10 NAME OF FATHER

Kerney Cofield.(C)

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

North Carolina

## 12 MAIDEN NAME OF MOTHER

Susan Burton.(C)

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

North Carolina

14 Informant Isabelle Cofield.(C) wife.  
(Address) 1209 W. Lanvale St.

15 Filed 19 1928 G. HAMILTON JONES M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1928<sup>92</sup>

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Drowning.

Accidental fall from a scow.

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (Secondary)

(duration) .....yrs. ....mos. ....ds.  
(Signed) O. H. Hamilton M. D.  
(Coroner)

5/14 1928 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

at place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Onfield N. C. 5/15 1928  
20 UNDERTAKER Daniel E. Carter ADDRESS 916  
Ogden

very important. See instructions on back of certificate.



E 33926

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161-001  
E 33926

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4087 N. Glover St. 6-10 Ward)2-FULL NAME Infant. Tribull(a) RESIDENCE NO. 4087 N. Glover St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced Infant  
HUSBAND or (or) WIFE of6 DATE OF BIRTH (month, day, and year) May 13 - 19287 AGE  
Years Months Days  
IF LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER Frank S. Tribull11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Margaret F. Bunt13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)14 Informant Margaret F. Tribull  
(Address) 4087 N. Glover15 Filed May 15 1928 G. H. JONES, M. D.  
Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 19 2817 I HEREBY CERTIFY, That I attended deceased from 5-13, 19 28 to 5-13, 19 28that I last saw him alive on 5-13, 19 28 and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH\* was as follows:

Premature Birth (5 1/2 mos)CONTRIBUTORY Placenta previa  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Levitt M. D.(Address) 4137 N. Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St VincentsMay 15 1928

20 UNDERTAKER

Leo B. Cook

ADDRESS

6152

very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33927

## CERTIFICATE OF DEATH

129 E 33927

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *609 N. Robinson* ST., *7-11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME *William H. Vohs*(a) RESIDENCE NO. *609 N. Robinson* ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *26* yrs. *1* mos. *7* ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *March 6-1900*7 AGE Years *28* Months *2* Days *7* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Electrical Engineer*(b) General nature of industry, business, or establishment in which employed (or employer) *030*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *Rudolph H. Vohs*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Mary A. Walzrop*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*11 Informant *Mary A. Vohs*(Address) *609 N. Robinson St.*15 Filed *15-1928* C. H. HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13-28*17 I HEREBY CERTIFY that I attended deceased from *May 6* 19 *28* to *May 13* 19 *28* that I last saw him alive on *May 12* 19 *28*

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*(duration) yrs. *3* mos. ds.CONTRIBUTORY *Chronic Convulsion*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis?

(Signed) *William F. Ry. Dams* M. D.(Address) *805 N. Avenue*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Woodlawn Cem.*

DATE OF BURIAL

*May 16 19 28*

20 UNDERTAKER

*George W. Zinkler*

ADDRESS

*1737 E. Coqu*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33928

## CERTIFICATE OF DEATH.

66 E 33928

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hosp. 19-28 Ward)2-FULL NAME Elmer F. Meekens(a) RESIDENCE NO. 1109 Wilkens Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 1/2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)MalewhiteSingle6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

8 DATE OF BIRTH (month, day, and year)

May 14 - 1901

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.261128

## 9 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workMusician(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 10 BIRTHPLACE (city or town)

(State or country)

Balto11 NAME OF FATHER Hyland Meekens

## 12 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto13 MAIDEN NAME OF MOTHER Anna E. Shipley

## 14 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto

15

Informant  
(Address)Hyland Meekens  
1709 Wilkens Ave

16

Filed

17

H. J. JONES, R. D.

1 Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 15 1928

17

I HEREBY CERTIFY, That I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by  
And that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Alcoholism  
3 1/2 years  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)Mr. B. J. Fortson M. D.  
(Signed) (Coroner)  
May 14, 1928 (Address) Curtis Bay\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Means and Nature of Injury, and (2) Whether  
Accidental, Suicidal, or Homicidal. (See reverse side of form.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death!

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

London Park Cemetery May 15 1928

## 20 UNDERTAKER

ADDRESS

Harry Mumaw 4204 Redwood Lane

OF DEATH IN PAIR FORM, See instructions on back of certificate.

E 33929

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Baltimore City Hospital*)

## 2-FULL NAME

*Henry F. Durand*

## (a) RESIDENCE NO.

*Jones' Creek*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. *2* ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 Color or Race

*W*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*May 13 / 1882*

## 7 AGE

Years

Months

Days

*45**14**29*IF LESS than  
1 day.....hrs.  
or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Weigh Master*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Bethlehem Steel*

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

*Elizabeth town  
New York*

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Frederick E Durand  
New York*

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Fannie Scherbaum  
New York*

## 14

Informant  
(Address)*Mrs Jennie Walker  
Brooklyn New York*15 Filed *15 1928**U. H. JONES, M. D.*  
Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*May 11 1928*17 I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry.  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:*Incar Hernia*

## CONTRIBUTORY (Secondary)

*Post Oper Shock*  
*J. C. Glades*  
*14/28*  
*14376 Bway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.  
Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

## 20 UNDERTAKER

*Brooklyn N. Y.*  
*John F. Denny*  
*715 Light St*



33930

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33930

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Ashland Ave 10-14

## 2. FULL NAME

Mary Suber

(a) RESIDENCE NO. 1303 Ashland Ave

(Usual place of abode)  
Length of residence in city or town where death occurred 15 yrs.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced  
(or) WIFE of

John Suber

6 DATE OF BIRTH (month, day, and year)

7 AGE

51

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

1877

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Cumberland Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Cumberland Md.

12 MAIDEN NAME OF MOTHER

Mary Wallace

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Cumberland Md.

14 Informant  
(Address)Eularia Guest (daughter)  
1303 Ashland Ave

15 Filed

15 1928

HAYSON JONES, M. D.

Registrar

How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1928

17

HEREBY CERTIFY, That I attended deceased from May 1, 1928, to May 13, 1928.

that I last saw him alive on May 12, 1928.

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic  
Parenchymatous Nephritis  
& Generalized Atherosclerosis

CONTRIBUTORY (Secondary) Intest. Insufficiency

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Jones, M. D.

(Address) 1724 E. Monument

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel cemetery May 15 1928

20 UNDERTAKER

Mrs R A Elliott 1724 Ashland Ave

# Verdecchio

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33931

E 33931

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 S. High St. ST. 3-5 WARD)

## 2-FULL NAME

Big Verdecchio

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 219 S. High St. ST. 3-5 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M.

## 4 COLOR OR RACE

W.

## 5 Single, Married, Widowed, or Divorced, (write the word)

Infant

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

## 6 DATE OF BIRTH (month, day, and year)

May 15/1928

## 7 AGE

Years

Months

Days

If LESS than 1 day, 2 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Pasquale Verdecchio

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Camilla Ricci

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

Halter

## 15

Filed

MAY 15 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1928

17

I HEREBY CERTIFY, That I attended deceased from May 18 1928 to May 18 1928, that I last saw him alive on May 15 1928, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Seven month Premature Pregnancy

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Joseph L. Vankar M. D.

Address

18 E. Morris

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

Holy RedeemerMay 15 1928Wendell J. DwyerHigh-Eden

TION is very important. See instructions on back of certificates.

E 33932

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

49 E 33932  
REGISTERED NO.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 320 S Regester 2-4 Ward)

2-FULL NAME John M Murphy

(a) RESIDENCE NO. 320 S Regester Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day hrs.  
or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15 Filed

19

JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 19 27 to May 13 19 28

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Carcinoma of the Prostate

CONTRIBUTORY

(Secondary)

(duration) 1 yrs. 3 mos. ds.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical &amp; Laboratory

(Signed)

19 25 May 14 (Address)

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33933

E 33933

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4-7 Ward)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lyda Hefner(a) RESIDENCE NO. Mercy Hospital - Troy, W. Va.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? 2 yrs. 0 mos. 27 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

April-18-1926

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.

2

0

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) Troy

(State or country)

W. Va.

10 NAME OF FATHER Hayward Hefner11 BIRTHPLACE OF FATHER (city or town) Troy

(State or country)

W. Va.

12 MAIDEN NAME OF MOTHER Glenna Butcher13 BIRTHPLACE OF MOTHER (city or town) Troy

(State or country)

W. Va.

14

Informant

Hayward Hefner (father)

(Address)

Troy, W. Va.

15 Filed

MAY 15 1928

C. HAMMON JONES

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 13 / 1928

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquest find that said deceased came to her death  
(topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Obstruction Larynx Cervical  
Due to rupture of L. 1. administered by  
Since Feb 24 (duration) Yrs. mos. ds.CONTRIBUTORY  
(Secondary)Pneumonia Thorax(duration) Yrs. mos. ds.(Signed) W. T. Riley  
(Coroner)

M. D.

1928 (Address)

1639 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 0 yrs., 0 mos., 12 ds. In the 0 yrs., 0 mos., 12 ds.

Where was disease contracted, if not at place of death?

Probably at Troy, W. Va.Former or usual residence Troy, W. Va.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Troy, W. Va.

Date of Burial

May-15-28

ADDRESS

100 W. NORTH AVE.20 OFFICE TAKER  
WILLIAM F. WOODEN, Successor



## HEALTH DEPARTMENT--CITY OF BALTIMORE

E 33934

E 33934

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 18-7A Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Fullman(a) RESIDENCE NO. 926 Lemmon St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown 1862

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min..

66

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

Md

10 NAME OF FATHER

Joseph Martin

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Minnie May

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

M. Frank Fullman  
1020 Madison St

15 Filed

C. 19

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/28

17

I HEREBY CERTIFY, That I attended deceased from

5/7/28, 19\_\_\_\_, to 5/14/28, 19\_\_\_\_,that I last saw her alive on 5/14/28, 19\_\_\_\_,and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Left Parotid Gland.(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cachexia(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? Clinical(Signed) J. S. Womack

M. D.

, 19

(Address)

Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

New Catholic CemeteryMay 17, 1928

20 UNDERTAKER

ADDRESS

John J. Bowman & Son, Inc.

Very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33935

33935

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 Lyman Ave ST. 27-48 WARD)

## 2-FULL NAME

Jessie M. Tracey

(a) RESIDENCE NO.

405 Lyman Ave

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

9 yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white

Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 4, 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

4

10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Co., Md

10 NAME OF FATHER

Wm. H. Tracey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Co., Md

12 MAIDEN NAME OF MOTHER

Ann C. Moford

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Co., Md

14

Informant (Address)

Mrs. Rosa S. Mayes

15

Filed

19

H. H. JONES, JR.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1928

17

I HEREBY CERTIFY, That I attended deceased from Apr 17, 1928, to May 14, 1928, that I last saw her alive on May 14, 1928, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH was as follows:

General Exhaustion brought about by Insanity - Heart became very weak -

(duration) 5 yrs. - mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

E. M. Duncan

M. D.

(Address) 5106 Ford Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Carmel, Balto. Co., Md.

May 17, 1928

20 UNDERTAKER

Wm. C. Brooks &amp; Son

Sparks, Md

TION is very important. See instructions on back of certificates.

E 33936

## HEALTH DEPARTMENT—CITY OF BALTIMORE 33936

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1644 Ashland ST., 13 WARD)

2. FULL NAME *Wallis J. Collins*

(a) RESIDENCE NO. 1644 Ashland ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE *Caucas* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Sarah Collins*

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE Years 43 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*(b) General nature of industry, business, or establishment in which employed (or employer) *440*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *M. C.*10 NAME OF FATHER *Mickerson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Sarah Collins* (Address) 1644 Ashland ST.

15 Filed 1928 HARRISON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13 1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 10*, 1928, to *May 13*, 1928.that I last saw him alive on *May 13*, 1928.and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic interstitial nephritis*

(duration) yrs. 8 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Exam. of urine* (Signed) *Robert J. Green* M. D.5-15, 1928 (Address) 120 *Albion St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Mt Calvary Cem**5/15 1928*

20 UNDERTAKER

ADDRESS

*Byron Wright 1218 McElderry St.*

CAUSE OF DEATH is very important. See instructions on back of certificates.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33938

## CERTIFICATE OF DEATH.

129 E 33938

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808, White)

## 2-FULL NAME

(a) RESIDENCE NO. 1808 White

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) May 13 19 28

## 17

I HEREBY CERTIFY, That I attended deceased from April 5, 19 28, to May 13, 19 28, that I last saw him alive on May 12, 19 28.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Ch. Intestinal  
Reflux

## CONTRIBUTORY (Secondary)

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33939

## CERTIFICATE OF DEATH.

129 E 33939  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 N. Lombard ST. 19-28 WARD)

2-FULL NAME Mary Emily Wilderman

(a) RESIDENCE NO. 1417 N. Lombard ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced. (write the word) widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Francis M. Wilderman

6 DATE OF BIRTH (month, day, and year) Jan 15-1847

7 AGE Years 81 Months 3 Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Payneham (State or country) Mass.

10 NAME OF FATHER Charles Wilbur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nova Scotia

12 MAIDEN NAME OF MOTHER Mary Bump

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Miss Alice Horst (Address) 1417 N. Lombard

15 Filed 15 1928 19 11-11-28 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1928

17

I HEREBY CERTIFY, That I attended deceased from Nov 22, 1927, to May 13, 1928.

that I last saw her alive on May 13, 1928

and that death occurred, on the date stated above, at 10.15 P. m

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

CONTRIBUTORY (Secondary)

Chronic Pharyngitis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

5/14, 1928 (Address) 1837 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Judson Park bur

May 16 1928

2238 14 North

Wm Bouton

E 33940

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33940

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals (T.B.) ST. 5-8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Harry Barry

## (a) RESIDENCE NO.

211 Forest st.

(Usual place of abode)

ST. 5-8 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widower

## 5a If married, widowed, or divorced

HUSBAND of  
or) WIFE of

Unknown

## 6 DATE OF BIRTH (month, day, and year) 1861

## 7 AGE

67

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

## 10 NAME OF FATHER William Barry

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

New York

## 12 MAIDEN NAME OF MOTHER Martha Doral

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## 14

Informant Hospital Records  
(Address)

## 15

Filed 15 1928

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1928

17

I HEREBY CERTIFY, That I attended deceased from  
April 9, 1928, to May 9, 1928,

that I last saw him alive on May 9, 1928,

and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary tuberculosis*(duration) 1 year yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? *Chemical test*(Signed) *Henry C. Smith* M. D.5-9-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## 20 UNDERTAKER

## DATE OF BURIAL

## ADDRESS

*George J. Hall**546 1928*  
*1735 Harper*

E 33941

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. 33941

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Stickler(a) RESIDENCE NO. 2315 E. Chase St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lillian Stickler

6 DATE OF BIRTH (month, day, and year)

9/27/1886

7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min..

41717

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Letter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto  
MD

PARENTS

10 NAME OF FATHER

N. Stickler

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Lillian Stickler  
2315 E. Chase St

15 Dated

MAY 15 1928HAMPTON JONES

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/28 19

17

I HEREBY CERTIFY, That I attended deceased from

5/12/28, 19, to 5/14/28, 19that I last saw him alive on 5/14/28, 19and that death occurred, on the date stated above, at 12:20 m.

The CAUSE OF DEATH\* was as follows:

Probably Coronary Embolism(duration) Sudden yrs. mos. ds.CONTRIBUTORY Hypertrophic Cirrhosis(Secondary) as Liver and ChronicAlcoholism (duration) 20 yrs. mos. ds.

18 Where was disease contracted

if not at place of death? +Did an operation precede death? + Date of -Was there an autopsy? -What test confirmed diagnosis? Clinical(Signed) J. S. Woodward, M. D., 19 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Hay Ridge Cemetery May 18 1928

20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Maryland



E 33942

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33942

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *20 E. Overlea Ave.*)2-FULL NAME *Mary E. Burns*(a) RESIDENCE NO. *20 E. Overlea Ave.*

(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Married*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*James F. Burns*6 DATE OF BIRTH (month, day, and year) *Feb 4, 1867*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*61**3**9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at Home*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Ireland*10 NAME OF FATHER *Wm. Connamagh*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Ireland*12 MAIDEN NAME OF MOTHER *Mary Bramon*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ireland*

14

Informant  
(Address)*Mr. James F. Burns  
20 E. Overlea Ave.*

15

Filed

19

*C. HARRISON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 27, 1928, to May 13, 1928.*that I last saw him alive on *May 13, 1928.*and that death occurred, on the date stated above, at *10:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*(duration) *5* yrs. *5* mos. *5* ds.CONTRIBUTORY  
(Secondary)(duration) *3* yrs. *3* mos. *3* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical signs*(Signed) *Edmund Benson, M. D.*

5/14, 1928 (Address)

*Overlea Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*New Cathedral Cemetery May 16, 1928*

20 UNDERTAKER

ADDRESS

*Elmer W. Conklin 924 E. Eager St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33943

## CERTIFICATE OF DEATH.

18 E 33943

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3206 Vickers Road 15-61 Ward)2-FULL NAME Hester Janette Gibbs(a) RESIDENCE NO. 3206 Vickers Road Ward

(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. 5 mos. 15 ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single6 DATE OF BIRTH (month, day, and year) Nov 30-18447 AGE Years 83 Months 5 Days 15 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)10 NAME OF FATHER Edwin Ashbury Gibbs11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)12 MAIDEN NAME OF MOTHER Edgar Helena Snowden13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)14 Informant G. B. Bristol (Address) 3206 Vickers Road15 Filed 5-19-28 16 REGISTRAR HAMPTON JONES M. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said Inquest (Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Obstruction of IntestinesCONTRIBUTOR Fracture Right Hip (Second) Fall Accident (duration) yrs. mos. ds.(Signed) H. B. Link M. D. (Coroner) May 15-1928 (Address) Coroner

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem Date of Burial May 16 192820 UNDERTAKER J. J. Tucker Jones ADDRESS not a line

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33944

E 33944

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3724 Boarman Ave. ST. 58, WARD 5-63)

## 2-FULL NAME

George Wollers

## (a) RESIDENCE NO.

3724 Boarman Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

58

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of or WIFE of

Ella F. Wollers

## 6 DATE OF BIRTH (month, day, and year)

July 1, 1854

## 7 AGE

Years

73

Months

10

Days

12

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grocery Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired 2 yrs.

(c) Name of employer

Germany

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

Fred K. Wan

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Mrs. Ella F. Wollers 3724 Boarman Ave.

## 15

Filed

19

HAMILTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Apr. 7, 1928, to May - 13, 1928, that I last saw him alive on May 13, 1928, and that death occurred, on the date stated above, at 1:55 P. M.

## The CAUSE OF DEATH\* was as follows:

Cerebral Arteriosclerosis with right hemiplegia.

## CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. 7 ds.

(duration) yrs. 2 mos. 2 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed)

Wesley Cole, M. D.

5/14, 1928 (Address) 2707 1/2 Mont.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Lorraine Cap.

## DATE OF BURIAL

May 16, 1928

## 20 UNDERTAKER

Wm. Michael Jones North Pa.

E 33945

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33945

## 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. *15-61* St. *Ward*)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Anna E. Griesse*(a) RESIDENCE NO. *3200 Elgin*St. *Ward*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *46* yrs. *5* mos. *19* ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F*4 Color or Race *W*5 Single, Married, Widowed, or Divorced (write the word) *Single*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*6 DATE OF BIRTH (month, day, and year) *11/20/1887*

7 AGE

Years *46*Months *5*Days *19*

IF LESS than 1 day.....hrs. or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *United Ry. Co*9 BIRTHPLACE (city or town) (State or country) *Baltimore, Md.*10 NAME OF FATHER *J.H. Griesse*11 BIRTHPLACE OF FATHER (City or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Mary Strocker*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *W. J. Jones*

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/14/28*

17

I HEREBY CERTIFY, That I attended deceased from *5/8/28* to *5/14/28*that I last saw him alive on *5/14/28*and that death occurred, on the date stated above, at *2:30 a.m.*The CAUSE OF DEATH\* was as follows: *Lobar pneumonia*

CONTRIBUTORY

(Secondary)

18 Where was disease contracted *Home*

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Autopsy*(Signed) *J. W. Jones*

19

(Address) *W. J. Jones*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *London Park Cemetery*Date of Burial *May 16 1928*20 UNDERTAKER *W. J. Jones*ADDRESS *W. J. Jones*

very important. See instructions on back of certificates.



E 33946

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33946

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *103 Oakwood* ST., *25-7* WARD *31*)2. FULL NAME *Martin Gunders*(a) RESIDENCE NO. *103 Oakwood*

(Usual place of abode)

Length of residence in city or town where death occurred *life*

mos.

ds.

How long in U. S., if of foreign birth? *life*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Nov. 8, 1900.*

7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or .... min.

*27**6**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Upholsterer*

(b) General nature of industry, business, or establishment in which employed (or employer)

*B. & O. R. R.*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Md.*

10 NAME OF FATHER

*Michael Gundert*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Elizabeth Heumt*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Mr. Michael Gundert**103 Oakwood Ave. Wilhelm Park*

15

*5 1928**C. HAMPTON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*May 13 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 21, 1928* to *May 13, 1928*

that I last saw him alive on

*May 11, 1928*

and that death occurred, on the date stated above, at

*6:30 m.*

The CAUSE OF DEATH\* was as follows:

*Pulmon. Tuberculosis*

(duration)

*1* yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*

What test confirmed diagnosis?

*was at Lauatoma*

(Signed)

*J. G. Dill* M. D.Address *1509 W. Lombard St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cemetery**5/16/28,*

20 UNDERTAKER

ADDRESS

*Harry N. Witzke, 1531 N. Lombard St.*

E 33947

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hsp. 28-28 Ward)

## 2-FULL NAME

Marie C. Uhl

## (a) RESIDENCE NO.

2017 Wilhelm

St.

Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Nov 18<sup>th</sup> 1890

## 7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.37525

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Pa.

## 10 NAME OF FATHER

August J. Uhl11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Germany

## 12 MAIDEN NAME OF MOTHER

Marie Oefner13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Germany

## 14

Informant  
(Address)Anna Uhl  
2017 Wilhelm St.

## 15

Filed

19

HARRISON JONES

Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 33947

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 13<sup>th</sup> 192817 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy + acute Cardiac Failure  
(duration) .....yrs. ....mos. ....ds. 12 hrs.

## CONTRIBUTORY (Secondary)

(Signature)

Thos. B. Horton M. D.  
(Coroner)May 14<sup>th</sup> 1928 (Address) Curtis Bay

\*State the Disease Causing Death or in death from Causes, state (1) Means and Nature of Injury and whether dental, Suicidal, or Homicidal. (S. 11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340-1341-1342-1343-1344-1345-1346-1347-1348-1349-1350-1351-1352-1353-1354-1355-1356-1357-1358-1359-1360-1361-1362-1363-1364-1365-1366-1367-1368-1369-1370-1371-1372-1373-1374-1375-1376-1377-1378-1379-1380-1381-1382-1383-1384-1385-1386-1387-1388-1389-1390-1391-1392-1393-1394-1395-1396-1397-1398-1399-1400-1401-1402-1403-1404-1405-1406-1407-1408-1409-1410-1411-1412-1413-1414-1415-1416-1417-1418-1419-1420-1421-1422-1423-1424-1425-1426-1427-1428-1429-1430-1431-1432-1433-1434-1435-1436-1437-1438-1439-1440-1441-1442-1443-1444-1445-1446-1447-1448-1449-1450-1451-1452-1453-1454-1455-1456-1457-1458-1459-1460-1461-1462-1463-1464-1465-1466-1467-1468-1469-1470-1471-1472-1473-1474-1475-1476-1477-1478-1479-1480-1481-1482-1483-1484-1485-1486-1487-1488-1489-1490-1491-1492-1493-1494-1495-1496-1497-1498-1499-1500-1501-1502-1503-1504-1505-1506-1507-1508-1509-1510-1511-1512-1513-1514-1515-1516-1517-1518-1519-1520-1521-1522-1523-1524-1525-1526-1527-1528-1529-1530-1531-1532-1533-1534-1535-1536-1537-1538-1539-1540-1541-1542-1543-1544-1545-1546-1547-1548-1549-1550-1551-1552-1553-1554-1555-1556-1557-1558-1559-1560-1561-1562-1563-1564-1565-1566-1567-1568-1569-1570-1571-1572-1573-1574-1575-1576-1577-1578-1579-1580-1581-1582-1583-1584-1585-1586-1587-1588-1589-1590-1591-1592-1593-1594-1595-1596-1597-1598-1599-1600-1601-1602-1603-1604-1605-1606-1607-1608-1609-1610-1611-1612-1613-1614-1615-1616-1617-1618-1619-1620-1621-1622-1623-1624-1625-1626-1627-1628-1629-1630-1631-1632-1633-1634-1635-1636-1637-1638-1639-1640-1641-1642-1643-1644-1645-1646-1647-1648-1649-1650-1651-1652-1653-1654-1655-1656-1657-1658-1659-1660-1661-1662-1663-1664-1665-1666-1667-1668-1669-1670-1671-1672-1673-1674-1675-1676-1677-1678-1679-1680-1681-1682-1683-1684-1685-1686-1687-1688-1689-1690-1691-1692-1693-1694-1695-1696-1697-1698-1699-1700-1701-1702-1703-1704-1705-1706-1707-1708-1709-1710-1711-1712-1713-1714-1715-1716-1717-1718-1719-1720-1721-1722-1723-1724-1725-1726-1727-1728-1729-1730-1731-1732-1733-1734-1735-1736-1737-1738-1739-1740-1741-1742-1743-1744-1745-1746-1747-1748-1749-1750-1751-1752-1753-1754-1755-1756-1757-1758-1759-1760-1761-1762-1763-1764-1765-1766-1767-1768-1769-1770-1771-1772-1773-1774-1775-1776-1777-1778-1779-1780-1781-1782-1783-1784-1785-1786-1787-1788-1789-1790-1791-1792-1793-1794-1795-1796-1797-1798-1799-1800-1801-1802-1803-1804-1805-1806-1807-1808-1809-1810-1811-1812-1813-1814-1815-1816-1817-1818-1819-1820-1821-1822-1823-1824-1825-1826-1827-1828-1829-1830-1831-1832-1833-1834-1835-1836-1837-1838-1839-1840-1841-1842-1843-1844-1845-1846-1847-1848-1849-1850-1851-1852-1853-1854-1855-1856-1857-1858-1859-1860-1861-1862-1863-1864-1865-1866-1867-1868-1869-1870-1871-1872-1873-1874-1875-1876-1877-1878-1879-1880-1881-1882-1883-1884-1885-1886-1887-1888-1889-1890-1891-1892-1893-1894-1895-1896-1897-1898-1899-1900-1901-1902-1903-1904-1905-1906-1907-1908-1909-1910-1911-1912-1913-1914-1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33948

E 33948

## 1—PLACE OF DEATH

CITY OF BALTIMORE:

## 2—FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)6a If married, widowed or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town).  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town).  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town).  
(State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
March 22, 1928, to May 13, 1928  
that I last saw him alive on May 13, 1928  
and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage  
and coma

CONTRIBUTORY

(Secondary)

Atherosclerosis of  
coronary arteries (duration) 4 yrs. 6 mos. 10 ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

E 33949

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

68 E 33949

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1839 Prestman*)ST. *15-71* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Emory Johnson*(a) RESIDENCE No. *1839 Prestman*

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M*

4 COLOR OR RACE

*C*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of or WIFE of

*Rosie Johnson*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, how or min.

*48**7**13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Warison Chemical*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Magothy Md*

10 NAME OF FATHER

*Clathus Johnson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Magothy Md*

12 MAIDEN NAME OF MOTHER

*Susie Watts*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md*

14

Informant (Address)

*Rosie Johnson 1839 Prestman*

15

Filed 19

*5-1928**C. HAMPTON JONES, D. D. RKA Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13 1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 6*, 19*28*, to *May 13*, 19*28*, that I last saw him on *May 12*, 19*28*, and that death occurred, on the date stated above, at *12:40 A* m.

The CAUSE OF DEATH was as follows:

*myocardial infarction - Rubele*

CONTRIBUTORS (secondary)

*at work*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*at work*

Did an operation precede death?

*no*

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*W. E. Jones M. D. 508 Jones St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Magothy Md Co.*

DATE OF BURIAL

*5/16 1928*

20 UNDERTAKER

*Byron Wright 1218 McElderry St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33950

## CERTIFICATE OF DEATH.

E 33950

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *722 Greenmount* St. *10* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *722 Greenmount* St. *10* Ward

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Nathans Jara*6 DATE OF BIRTH (month, day, and year) *March 25-1866*7 AGE *62* Years Months *1* Days *19* IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Hurfi*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) *Austria*10 NAME OF FATHER *Carl Jara*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Austria*

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address) *Nathans Jara*  
*722 Greenmount*

15-1928

C. HAMMOND JONES, M. D.

Per

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 14* 192817 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, au-topsy or inquiry.) find that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Accidents by Illuminating Gas*  
*Under Low* (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Found dead* (duration) yrs. mos. ds.Signed) *W. T. Riley* M. D., 1928 Address) *1639 Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death:

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR

Date of Burial

*Holy Cross Brooklyn**May 17, 28*

## 20 UNDERTAKER

ADDRESS

*John H. Valentin**22265*

very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33951

## CERTIFICATE OF DEATH.

E 33951

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 7-4 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

/ ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number, and fill out No.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

Male White

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 22 1928

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

14 weeks 2

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Milwaukee

10 NAME OF FATHER

Herman Schneider

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Wis

12 MAIDEN NAME OF MOTHER

Hazel Tenlow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Wis

14

Informant

(Address)

Hazel M. Schneider

Milwaukee

15 Filed

C. HAMPTON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 15 1928

17

I HEREBY CERTIFY that I took charge of the

remains described above, held an  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

Inquest, au-  
topsy or inquiry.) and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Hydrocephalus

CONTRIBUTORY

(Secondary)

Male

15/28

19

(Address)

C. Lauster

J. C. Blakes

1436 Bway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Milwaukee Wis

5/15/28

20 UNDERTAKER

ADDRESS

Joseph Abrams

2716 Bway

very important. See instructions on back of certificate.

E 33952

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33952

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

Miniminty Hospital

CITY OF BALTIMORE: (No.

Lombard &amp; Greene ST.

WARD)

2. FULL NAME

Arthur T. Heath

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Glen Burnie, Md

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Margaret Heath.

6 DATE OF BIRTH (month, day, and year)

May 26 1873

7 AGE

54

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Wm. T. Heath

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Susan Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Miniminty Hospital

15

Filed

19

C. HAMPTON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 14 1928

17

I HEREBY CERTIFY, That I attended deceased from

April 12, 1928, to May 14, 1928,

that I last saw him alive on May 14, 1928,

and that death occurred, on the date stated above, at 10<sup>12</sup> A. M.

The CAUSE OF DEATH\* was as follows:

arteriosclerotic Cardio Vascular Renal Disease

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed)

H. E. Riepschneider, M. D.

7-4, 1928 (Address)

Miniminty Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Moyothey Cemetery A.A. Cabal

5/16 1928

20 UNDERTAKER

ADDRESS

John F. Denny

715 1/2 St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33953

## CERTIFICATE OF DEATH.

E 33953

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 4032 Belle Ave St. 15-63 Ward)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

11 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,

or Divorced. (write the word)

Male WhiteMarried

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Annie C. Baer

6 DATE OF BIRTH (month, day, and year)

Sept? 1862

7 AGE

Years

Months

Days

IF LESS than

1 day.....hrs.

or.....min.

658?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

York Co. Pa

10 NAME OF FATHER

John Baer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Langston Co. Pa

12 MAIDEN NAME OF MOTHER

Jane ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pa

14

Informant

(Address)

Mrs Annie C. Baer4032 Belle Ave

15 Filed

C. HAMMON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1928

May 13<sup>th</sup>

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....Inquest.....  
(Inquest, autopsy or inquiry)thereon and from the evidence obtained by said.....  
(Inquest, au-topsy or inquiry.)  
and that said deceased came to.....his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Ulcerated Colitis(duration) one.....mos.....ds.CONTRIBUTORY  
(Secondary)

(Signature)

M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Delta, PaMay 10<sup>th</sup> 28

20 UNDERTAKER

ADDRESS

H. J. Tucker, Jones703 Lane

very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33954

E 33954

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 187 Gittings Ave. Gorsus ST. 27-48 WARD)2-FULL NAME Frederick C. Bauer(a) RESIDENCE NO. 187 Gittings Ave. Gorsus ST. 27-48 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie F. Bauer6 DATE OF BIRTH (month, day, and year) Aug 10, 18707 AGE Years 57 Months 9 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Flonist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER Henry Bauer11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Mary Andise13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant William Bauer (Address) 187 Gittings Ave. Gorsus15 Filed 15-1928 19 HAMPTON JONES, M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13 19 2817 I HEREBY CERTIFY, That I attended deceased from May 7, 1928, to May 13, 1928, that I last saw him alive on May 13, 1928, and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY Hypertension Arterio Sclerosis (Secondary)(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) H. C. Hoess, M. D.5-14, 1928 (Address) 5600 York Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT Baltimore CemeteryDATE OF BURIAL May 16, 192820 UNDERTAKER E. Le Roy StufferADDRESS 125 E. North Ave.

(Paladinett)  
 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33955

## CERTIFICATE OF DEATH.

E 33955

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *West Baltimore Gen. Hospital*)2. FULL NAME *Mary Paladinett*(a) RESIDENCE NO. *1822 West 5th St. Wilmington Del.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

*13*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Unknown*6 DATE OF BIRTH (month, day, and year) *1868*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *Italy*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Unknown*

14

Informant  
(Address)*Hospital Records*

15

File

*16 1928*

19

*C. HAMPSON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 15 1928*

17

I HEREBY CERTIFY, That I attended deceased from *May 2*, 19 *28*, to *May 15*, 19 *28*, that I last saw her alive on *May 15*, 19 *28*, and that death occurred, on the date stated above, at *7:00 P. m.* The CAUSE OF DEATH\* was as follows:*Carcinoma of Esophagus and Cardiac End of Stomach*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary) *Cardiac Failure*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *May 4, 1928*Was there an autopsy? *No*What test confirmed diagnosis? *Same as operation*(Signed) *Paul Scheuer*

, 19

(Address) *West Balto. General Hospital*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Wilmington Del.*

DATE OF BURIAL

*May 16*

UNDERTAKER

*John A. Moran**300*

ADDRESS

*E. 13th*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33956

## CERTIFICATE OF DEATH

E 33956

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Worward General Hospital* St. *335* Ward)

## 2-FULL NAME

(a) RESIDENCE NO. *18 Summit Ave.* St. *335* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John Peacock*

6 DATE OF BIRTH (month, day, and year)

*12-18-1863*

7 AGE

*64* Years

Months

*65**4*

Days

*27*

IF LESS than 1 day..... hrs. or min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *(H.W. 037)*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Baltimore, Md.*10 NAME OF FATHER *John Schaffner*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore*12 MAIDEN NAME OF MOTHER *Margaret Bauer*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore*

14

Informant (Address)

*Hospital Records*

15 Filed

MAY 16 1928

19

HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

*5-15-28*

17

I HEREBY CERTIFY, That I attended deceased from

*5-13-28*, 19... to *5-15-28*, 19...that I last saw her alive on *5-15-28*, 19...and that death occurred, on the date stated above, at *4:10 P.* m.

The CAUSE OF DEATH\* was as follows:

*Appendiceal Abscess*

CONTRIBUTORY (Secondary)

(duration) yrs. *3 weeks* mos. ds.*acute hepatitis*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *yes* Date of *5-14-28*Was there an autopsy? *yes*What test confirmed diagnosis? *Clinical*(Signed) *E. C. Zimmerman, M. D.*, 19 (Address) *400 General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Woodlawn Cemetery May 16, 1928*

20 UNDERTAKER

ADDRESS

*H. S. Marshall 353 1st St. Rd*

33957

## HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

31 E 33957

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Sr.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(If write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15

Filed

191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS



# Louisa Wittich

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33958

## CERTIFICATE OF DEATH.

45 E 33958

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 East 33rd St. ST. 12-49 WARD)

## 2-FULL NAME

Louisa Wittich,

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

118 East 33rd St.

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

64 yrs.

— mos.

— ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 ~~Single, Married~~ Widowed, or ~~Divorced~~ (write the word)Female WhiteWidow5a If ~~married~~ widowed, or ~~divorced~~ HUSBAND of (or) WIFE ofGeorge Wittich,

## 6 DATE OF BIRTH (month, day, and year)

March 12, 1850

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7023

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

York, Penna.

## 10 NAME OF FATHER

Casper Louthardt,

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Unigundia Herzog,

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant (Address)

Miss J. S. Kirkness  
118 E. 33rd St.

## 15

Filed

16-1928 HARRISON JONES, M. D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

19

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb. 7, 1928 to May 15, 1928that I last saw her alive on May 14, 1928and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of colon  
(hepatic flexum)(duration) 1 yrs.  mos.  ds.

## CONTRIBUTORY (Secondary)

(duration) none yrs.  mos.  ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? noDate of Was there an autopsy? noWhat test confirmed diagnosis? X ray & physical

(Signed)

proabutscher M. D.

19

(Address)

12 E. 2nd St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

19

## 20 UNDERTAKER

## ADDRESS

Lorraine  
Geo. W. Little

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33959

## CERTIFICATE OF DEATH

E 33959

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *15-58* Ward)2-FULL NAME *Baby Girl Plimack*(a) RESIDENCE NO. *2367 Reservoir Rd* Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced; (write the word)

*Female White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *5/11/28*

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..*4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md*

(State or country)

10 NAME OF FATHER *Louis E. Plimack*11 BIRTHPLACE OF FATHER (City or town) *Baltimore, Md*

(State or country)

12 MAIDEN NAME OF MOTHER *Ellie D. Sless*13 BIRTHPLACE OF MOTHER (city or town) *Limerick*(State or country) *Ireland*

14

Informant  
(Address)*Mercy Hospital*

15 Filed

76 1928

C. H. HARRISON JONES, R. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/15/28* 19

17

I HEREBY CERTIFY, That I attended deceased from

*5/11/28*, 19....., to *5/15/28*, 19.....that I last saw her alive on *5/15/28*, 19.....and that death occurred, on the date stated above, at *2:30 P. M.*

The CAUSE OF DEATH\* was as follows:

*Adelactasia*(duration) yrs. mos. *4* ds.CONTRIBUTORY *Cardiac Dilatation*  
(Secondary)(duration) yrs. mos. *1/2* hr.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *Clinical*(Signed) *Erin Basse Holley* M. D.

. 19

(Address) *Mercy Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

*Balto Hebrew**5-16 1928*

20 UNDERTAKER

ADDRESS

*David Sandheim**118 W. Mt. Vernon*

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

E 33960

## HEALTH DEPARTMENT—CITY OF BALTIMORE

161 E 33960

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Univ. Hosp.* St. *4-30* Ward)

Registered No. ....

2-FULL NAME. *Baby Boy Tydings*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. *Annapolis, Md.* St. .... Ward ....

(Usual place of abode)

Length of residence in city or town where death occurred

*Bot 33*

(If non-resident give city or town and State)

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*White*

5-Single,

Married,

Widowed,

or Divorced,

(Write the word)

5a-If married, widowed, or divorced  
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

*5-11-28*

7-AGE.

If LESS than 1 day,

..... yrs. .... mos. .... ds.

*2 hrs. or. .... min.?*

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular  
kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) *Dulles, Md.*  
(State or Country)10-NAME OF  
FATHER, *Gabriel Tydings*11-BIRTHPLACE  
OF FATHER (city or town)*Charles Co. Md.*12-MAIDEN NAME  
OF MOTHER, *Agnes Jendraszkiewicz*13-BIRTHPLACE  
OF MOTHER (city or town)*Dalis. Md.*

14-

(Informant) .....

(Address) .....

15-

C. HANSON JONES, M. D.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). *5-11-28*

17- I HEREBY CERTIFY, That I attended deceased from

*5-11-28* to *5-11-28*that I last saw him alive on *5-11-28*and that death occurred, on the date stated above, at *4:05* in

The CAUSE OF DEATH\* was as follows:

*Prematurity*

(Duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

18-Where was disease contracted  
If not at place of death?Did an operation precede death? *no* Date of .....Was there an autopsy? *no*What test confirmed diagnosis? *P.P. and findings*(Signed) *Walter H. Reynolds* M. D.19 (Address) *University Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes  
state (1) Means and Nature of Injury, and (2) whether Accidental  
Suicidal, or Homicidal. (See reverse side for additional space.)19-PLACE OF BURIAL, CREMATION OR  
REMOVAL *University Hospital* DATE OF BURIAL, 19....

20-UNDERTAKER

ADDRESS

Instructions on back of certificates.

33961

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100 E 33961

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 446 E. Cross St. ST. 24-33 WARD)2. FULL NAME Dorothy J. Fry(a) RESIDENCE NO. 446 E. Cross St. ST. 24-33 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 1 mos. 1 ds.

(If non-resident give city or town and State)

WARD

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Jan. 7, 1927

7 AGE

Years

1

Months

4

Days

17

If LESS than 1 day, hrs or min

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John J. Fry

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Upper Strasburg Pa.

12 MAIDEN NAME OF MOTHER

Cecilia Divil

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Sistersville Ohio

14

Informant

(Address)

Mr. Cecilia Fry  
446 E. Cross St.

15

FILE

1928

HAIRSON JONES, M.D.  
Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1928

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1928 to May 14, 1928that I last saw him alive on May 14, 1928and that death occurred, on the date stated above, at 9:35 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Broncho  
(Primary) Pneumonia(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) R. H. Campbell, M.D.  
15728 (Address) 1644 Hancock St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cedar Hill Cem.May 16, 1928

20 UNDERTAKER

ADDRESS

Chas. H. Swinney4591  
14th Ave



E 33962

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Sinai Hospital

CITY OF BALTIMORE: (No.

ST.

WARD)

REGISTERED NO.

E 33962

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Valentini Jeller.

(a) RESIDENCE NO.

1600 N. Hurkum

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of or WIFE of

Mrs. Irene Jeller

6 DATE OF BIRTH (month, day, and year)

January 17, 1885

7 AGE

42

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

William Jeller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Gene Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto.

14

Informant (Address)

Mrs. Irene Jeller  
1600 N. Hurkum St.

15

Date

MAY 16 1928

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/28

17 I HEREBY CERTIFY, That I attended deceased from 5/12 1928 to 5/15 1928.

that I last saw him alive on 5/15 1928 and that death occurred, on the date stated above, at 7:05 P. M.

The CAUSE OF DEATH\* was as follows:

Bilateral Bronchopneumonia with Malaria &amp; Cardiac Failure

CONTRIBUTORY (Secondary) Cardiac Renal Complication

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

M. Sherry

M. D.

19 (Address)

Sinai Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Mt Carmel Cemetery

5/18 1928

20 UNDERTAKER

George J. Ruth 1735 Harbor Ave

E 33963

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33963

## 1-PLACE OF DEATH

City of BALTIMORE (No. 901) St. 23-31 Ward 129

## 2-FULL NAME

(a) Residence No. 901 Sharp St. (Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm

6-DATE OF BIRTH (month, day and year) ? 1867

7-AGE

61 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or...min.?

## 8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country)

Md

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

Unknown

14-

(Informant) Marie Rice

(Address) 1547 Argyle Ave

15-

File 16 1928 H. J. JONES, M. D. Registrar

## CERTIFICATE OF DEATH.

St. 23-31 Ward 129

St. Ward

(If non-resident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15 1928

17- I HEREBY CERTIFY, That I attended deceased from April 8 1928 to May 15 1928

that I last saw him alive on May 15 1928

and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH\* was as follows:

Acute hepatitis

(Duration) yrs. mos. ds. 8

CONTRIBUTORY (Secondary)

Acute Endocarditis

(Duration) yrs. mos. ds. 21

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Croyle, M. D.

19 (Address) 501 W. Humboldt

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

Catholic Cemetery 717 1928

20-UNDERTAKER

Mrs. Geo. H. Holland 1631 Druid Hill Ave

Instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33964

## CERTIFICATE OF DEATH.

90 E 33964

## 1-PLACE OF DEATH

CITY OF BALTIMORE NO

1062 Argyle

ST

WARD

## 2-FULL NAME

Cornelia Robinson

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## RESIDENCE NO

1062 Argyle

ST.

## WARD

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

55

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

X

(c) Name of employer

X

## 9 BIRTHPLACE (city or town) (State or country)

Balt Md

## 10 NAME OF FATHER

James William

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Mary William

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balt Md

## 14

Informant

Annie Harris

Address

1101 Argyle

## 15

Filed

JAMES H. JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 14 1928

## 17

I HEREBY CERTIFY That I attended deceased from

Dec 1927 to May 14 1928.

that I last saw him alive on May 13 1928.

and that death occurred, on the date stated above, at 6 4 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Heart Disease

Since Dec 17, (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Dropsy (duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mont Auburn

May 17 1928

## 20 UNDERTAKER

## ADDRESS

John H. Owen

538 10th

CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33965

## CERTIFICATE OF DEATH.

REGISTERED NO.

E 33965

## 1-PLACE OF DEATH

City of BALTIMORE (No. Hopkins Hospital St. 7-13 Ward)

2-FULL NAME Louis Knox

(a) RESIDENCE NO. 1644 Barnes st

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos.

St. Ward

(If non-resident give city or town and State)

How long in U. S. If of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 Color or Race white 5 Single, Married, Widowed, or Divorced, (write the word) -ingle

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE Years 52 Months Days IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Md

10 NAME OF FATHER

John Knox

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Anna Rosenthal

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14 Informant Hospital Records (Address)

15 Filed MAY 15 1928 HARTMAN JONES M. B. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9/28 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, an-

inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cirrhosis of Liver

(Autopsy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed)

(duration)

(Coroner)

M. D.

5/10/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Schwartz Cemetery

May 16 1928

20 UNDERTAKER

Sammy Sobers Son

ADDRESS

1301 E. Bay St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33966

## CERTIFICATE OF DEATH.

31 E 33966

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 736 W Franklin ST. 17-16 WARD)2-FULL NAME Daniel Taylor(a) RESIDENCE NO. 736 W Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Blk 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred Taylor6 DATE OF BIRTH (month, day, and year) June 28/19027 AGE Years Months Days 19 11 14 If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gustave Duncan9 BIRTHPLACE (city or town) Baltimore (State or country) md10 NAME OF FATHER Daniel Taylor11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)12 MAIDEN NAME OF MOTHER Ida Holbrook13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) md14 Informant Emma Holbrook (Address) 732 Pinner St15 Filed 15 1928 C. H. JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 192817 I HEREBY CERTIFY, That I attended deceased from May 5th, 1928, to May 12, 1928, that I last saw him alive on May 11th, 1928, and that death occurred, on the date stated above, at 9:55 P. m. The CAUSE OF DEATH\* was as follows:Pulmonary Tuberculosis (duration) yrs. 6 mos. — ds.CONTRIBUTORY (Secondary) Cardiac Dehydration (duration) yrs. — mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? clinical (Signed) Gustave Duncan, M. D., 19 (Address) 156 W Franklin

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT St. Ambrose Cem. DATE OF BURIAL May 12 192820 UNDERTAKER James H. Hensley ADDRESS 1121 E. 17th St.

TION is very important. See instructions on back of certificates.

E 33967

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST., *9-45* WARD)2-FULL NAME *Arthur Edmund Seer*(a) RESIDENCE NO. *601 Greenwood Ave*  
(Usual place of abode) *Pottsville, Penn.* ST.,

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 33967

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 1, 1908*

7 AGE

Years

Months

Days

*20**0**14*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Student*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Pottsville*  
(State or country) *Penn.*10 NAME OF FATHER *J. E. Seer*11 BIRTHPLACE OF FATHER (city or town) *Pottsville*  
(State or country) *Penn.*12 MAIDEN NAME OF MOTHER *Emma Pickel*13 BIRTHPLACE OF MOTHER (city or town) *Philadelphia*  
(State or country) *Penn.*14 Informant *J. E. Seer*  
(Address) *Pottsville, Penn.*15 Filed *1928* 19 *HAMILTON JONES, M.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 15, 1928*17 I HEREBY CERTIFY, That I attended deceased from *May 14*, 1928, to *May 15*, 1928, that I last saw him alive on *May 15*, 1928, and that death occurred, on the date stated above, at *6:50* p. m.

The CAUSE OF DEATH\* was as follows:

*Facial Erysipelas*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*Lobar pneumonia*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted & if not at place of death? *Gettysburg (Pa.) College*Did an operation precede death? *No* Date of *5-15-28*Was there an autopsy? *No* *Reinhardt*What test confirmed diagnosis? *Clinical*(Signed) *Dr. J. P. Levin*

M. D.

5-16, 1928 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

*Tottsville, Penn.*

DATE OF BURIAL

*5/16 1928*

20 UNDERTAKER

*William Cook*

ADDRESS

*802 E. North*

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33968

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 7-9 Ward)2-FULL NAME Rubie A. Mehornay(a) RESIDENCE NO. Sophian Plaza, Kansas City, Mo. Ward

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 3

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female

white

Widow

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Late Oscar F. Mehornay

6 DATE OF BIRTH (month, day, and year)

Dec 21/1876

7 AGE

Years

Months

Days

51

4

24

IF LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.....

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town)

(State or country)

Salem, Ind.

10 NAME OF FATHER

Charles M. Pearl

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Kentucky

12 MAIDEN NAME OF MOTHER Mattie Cosby

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Kentucky

14

Informant Robert L. Mehornay

(Address)

Kansas City, Mo.

15

FILE

19280 HARRISON JONES, M

Registrar

REGISTERED NO.

E 33968

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number and fill out No.  
18.)

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 14/28

17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-inquiry.....and that said deceased came to her death  
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Strangulation-Hung herself by  
belt in her room at hospital

(duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY Melancholia

(Secondary)

(duration) .....yrs. ....mos. ....ds.

(Signed)

(Coroner)

M. D.

5/16/28

(Address)

508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent  
Causes, state (1) Menns and Nature of Injury, and (2) Whether Acci-  
dental, Suicidal, or Homicidal. (See reverse side for additional space.)18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents.)

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR  
REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

502 E. North

E 33969

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 E 33969  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITAL ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bevin(a) RESIDENCE No. 1118 W. Court ST. 8 WARD 12

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Married5a If married, widowed, or divorced HUSBAND of or WIFE of Sallie Bevin6 DATE OF BIRTH (month, day, and year) Unknown 878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salvage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina10 NAME OF FATHER Free Bevin11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina12 MAIDEN NAME OF MOTHER Frances Currie13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14

Informant (Address) Records

15

Filed

MAY 16 1928

HARVEY JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/1928

17

I HEREBY CERTIFY, That I attended deceased from

May 12, 1928, to May 14, 1928that I last saw him live on May 14, 1928and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH\* was as follows:

Myocardial infarction & acute arteriosclerosis.  
Hypertension.(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? General & Sals(Signed) C. J. Holmes Boyd, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

UNDERTAKER

ADDRESS

Mount Calvary May 17, 1928  
Mrs. R. G. Elliott 725 Ashland



E 33970 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 E 33970

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Barnes St ST. 7-13 WARD)

## 2. FULL NAME

Ida Fleet

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1628 Barnes St

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

Col

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

## 6 DATE OF BIRTH (month, day, and year) June 15, 1913

## 7 AGE

14 Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

15

10

29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md.

## 10 NAME OF FATHER

Andrew Fleet

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

D.C.

## 12 MAIDEN NAME OF MOTHER

Lottie Hill

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

## 14

Informant  
(Address)Lottie Fleet  
1628 Barnes St

## 15

Filed

16 1928 HARRISON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) May 14 1928

## 17

I HEREBY CERTIFY, That I attended deceased from

May 4, 1928, to May 14, 1928.

that I last saw him alive on May 13, 1928,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Lobes Pneumonia  
Bilateral.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY  
(Secondary)

Acute Myocarditis

(duration) yrs. mos. 5 ds.

## 18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Calvin B. LeCompte, M. D.

, 19 (Address) 814 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

NOVA  
Baltimore County

May 17 1928

## 20 UNDERTAKER

## ADDRESS

Robert Williams 1515 M. St.

E 33971

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33971

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

Baltimore City Hospitals (T.B.)  
CITY OF BALTIMORE: (NO. ST., WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME John McLaurin

(a) RESIDENCE NO. 909 Rutland ave.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos.

ST., WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE Years 26 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) North Carolina (State or country)

10 NAME OF FATHER John McLaurin

11 BIRTHPLACE OF FATHER (city or town) North Carolina (State or country)

12 MAIDEN NAME OF MOTHER Eliza Fairley

13 BIRTHPLACE OF MOTHER (city or town) North Carolina (State or country)

14 Informant Hospital Records (Address)

15 Filed 15 1928 C. HAMPTON JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1928

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1928, to May 13, 1928, that I last saw him alive on May 13, 1928, and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Chemical &amp; Lab. (Signed) J. M. D.

5-13-28 (Address) Baltimore City Hospitals

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

Maple N. O.

5-16-1928

20 UNDERTAKER

ADDRESS

Daniel Easton

Ba. av.

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33972

## CERTIFICATE OF DEATH.

REGISTERED NO. \_\_\_\_\_

## 1-PLACE OF DEATH

City of BALTIMORE: (No. \_\_\_\_\_)

2x18 N. Balto St. Baltimore

## 2-FULL NAME

Famine Poulson

## (a) RESIDENCE NO.

840 W. Saratoga St.

Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 Color or Race

Cald

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

## 6a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown

1878

## 7 AGE

Years

Months

Days

IF LESS than 1 day.....hrs. or.....min.

about 48

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Va

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

## 14

Informant (Address)

Nellie Johnson 840 W. Saratoga St.

## 15 Filed

19

JAMES JONES

Registrar

## CORONER'S CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 14

1928

## 17

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

and that said deceased came to death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Hypertension

(duration)

at once

## CONTRIBUTORY (Secondary)

(Signed)

H. B. Corry

(Coroner)

15019 28 (Address)

Curtis Bay, Balto Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place

of death.....yrs.....mos.....ds.

In the

State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Ashbury Bur

5/16 1928

## 20 UNDERTAKER

H. B. Corry

ADDRESS

5/16

tion should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33973

33973

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *So. Balt. Gen. Hosp.* ST. *10-27* WARD)2. FULL NAME *Baty Boy Turner*(a) RESIDENCE NO. *1950 West. Franklin St.* ST. *10-27* WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *newborn*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *So. Balt. Gen. Hosp. Balt.* (State or country)10 NAME OF FATHER *Edwin Harm Turner*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Musbaum*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Westminster Md.*

14

Informant (Address) *mother*

15

C. HAMPTON JONES, M. D. Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/14* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from

*May 13*, 19*28*, to *May 14*, 19*28*.that I last saw him alive on *May 14*, 19*28*.and that death occurred, on the date stated above, at *3:05 P* m.

The CAUSE OF DEATH\* was as follows:

*Prematurity (6 months)*  
*(wt. 1 lb 2 1/2 oz)*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *history + sigs*(Signed) *William W. Chase*, M. D.19 (Address) *So. Balt. Gen. Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

UNIVERSITY OF MARYLAND.

20 UNDERTAKER

*General Hospital*

ADDRESS

MAY 15 1928

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

Boy Long

(a) RESIDENCE NO.

4819 A Hamell ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

5-12-28

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Md -

10 NAME OF FATHER

William Long

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Sophie Becker

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md -

14

Informant

(Address)

Records -

15

Filed

19

24550078

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 15-28

17

I HEREBY CERTIFY, That I attended deceased from  
May 13, 1928, to May 15, 1928,  
that I last saw him alive on May 15, 1928

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

A.C. Goodwin

M. D.

, 19

(Address)

Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

Commissioner Health

ADDRESS

MAY 16 1928

important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33975

## CERTIFICATE OF DEATH.

33975

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *13-59*)2-FULL NAME *Baby Jones*(a) RESIDENCE NO. *2325 Division St.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female Black*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 6, 1928*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER *Freddie Jones*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Catherine Peaker*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9* 19 *28*

17

I HEREBY CERTIFY, That I attended deceased from  
*5-6*, 19*28*, to *5-9*, 19*28*,that I last saw her alive on *5-9*, 19*28*,and that death occurred, on the date stated above, at *4:50 A* m.

The CAUSE OF DEATH\* was as follows:

*Ateloidosis*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Chas. W. Hamlin* M. D.3-18, 1928 Address *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*JOHNS HOPKINS HOSPITAL*  
*Commissioner of Health*BY: *Wm. E. Woodall*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

E 33976

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33976

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

JOHNS HOPKINS HOSPITAL

ST. \_\_\_\_\_

WARD) \_\_\_\_\_

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME *Boy Pinkston*(a) RESIDENCE NO. *1628 Mculloh*

(Usual place of abode)

ST. \_\_\_\_\_

WARD \_\_\_\_\_

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*Colored*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Bachelor*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*4/20/28*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*3 weeks**21*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Ind -*

## 10 NAME OF FATHER

*Edmund Pinkston*

## 11 BIRTHPLACE OF FATHER (city or town)

*Ind*

(State or country)

## 12 MAIDEN NAME OF MOTHER

*Anna Ford*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Ind*

(State or country)

## 14

Informant

*Barb*

(Address)

JOHNS HOPKINS HOSPITAL

JOHNS HOPKINS HOSPITAL

## 15

Filed

*16 1928*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*May 11-1928*

## 17

I HEREBY CERTIFY, That I attended deceased from

*May 11, 1928, to May 11, 1928,*that I last saw him alive on *May 11, 1928*and that death occurred, on the date stated above, at *7:45 P. m.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*(duration) yrs. mos. *3* ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. *2* ds.

## 18 Where was disease contracted

If not at place of death?

*at home*Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed)

*J. C. Goodwin*

M. D.

*5/13, 1928*

(Address)

*Johns Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

HOPKINS HOSPITAL

## DATE OF BURIAL

19

## 20 UNDERTAKER

ADDRESS

*MAY 16 1928*

important. See instructions on back of certificates.

E 33977

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 33977

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

Peter J. Brady

## (a) RESIDENCE NO.

(Usual place of abode)

122 Warwick Ave.  
5 weeksWARD Cranston, R.I.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth 4 1/2 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white5 ~~Single, Married, Widowed,~~  
or Divorced, (write the word)Widower

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Nov. 2, 1861

## 7 AGE

Years

Months

Days

13If LESS than  
1 day, ... hrs.  
or ... min.66614

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workretired(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Ireland

## 10 NAME OF FATHER

John Brady11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Ireland

## 12 MAIDEN NAME OF MOTHER

Bridget Kelly13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Ireland

## 14

Informant

(Address)

Records  
JOHNS HOPKINS HOSPITAL

## 15

Date

16 1928

19

C. HAMPSON JONES, M.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

5-15-28

## 17

I HEREBY CERTIFY, That I attended deceased from

Apr. 11, 1928, to May 15, 1928that I last saw him alive on May 15, 1928and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Bladder(duration) 3 yrs. mos. ds.CONTRIBUTORY  
(Secondary)Pneumonia  
(duration) yrs. mos. ds.18 Where was disease contracted  
If not at place of death?Did an operation precede death? No. Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Autopsy + Biopsy(Signed) James, M. D., 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Pawtucket, R.I.

## DATE OF BURIAL

5/16 1928

## 20 UNDERTAKER

Henry W. Mears & Son

## ADDRESS

805 N. Calvert

important. See instructions on back of certificates.

via Penn. Railroad Express - Rev. F. P. Brady



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33978

## CERTIFICATE OF DEATH.

18<sup>2</sup> E 33978

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 2109 Clinton St. 10<sup>th</sup> Ward)

## 2-FULL NAME

(a) RESIDENCE NO. 2109 S. Clinton Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 45 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 Color or Race

White5 Single, Married, Widowed,  
or Divorced, (write the word)Single6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug. 30-1876

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.51814

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workNone(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany10 NAME OF FATHER August Witte

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany12 MAIDEN NAME OF MOTHER Augusta Hamilton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant  
(Address)Mrs. Geo. Mack  
2109 S. Clinton St.

15 Filed

C. HAMPTON JONES, M. D.

Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1928

17

I HEREBY CERTIFY, that I took charge of the

remains described above, held an Inquiry  
(Inquest, autops, or inquiry.)

thereon and from the evidence obtained by said

Inquiry and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH was as follows:

Acc.Drowning

CONTRIBUTORY

(Secondary)

None(Address) 14376 Bivay

State the Disease Causing Death, or in deaths from Violent

Causes, state (1) Means and Nature of Injury, and (2) Whether Acci-

dental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-

ients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Int. Carmel Cemetery May 17 1928

ADDRESS

20 UNDERTAKER

George W. Zickler 1737 E. Eager St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 33979

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33979

## CERTIFICATE OF DEATH.

100-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3244 Chestnut* ST. *13-52* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME *Harry Shoemaker*(a) RESIDENCE NO. *3249 Chestnut* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* mos. ds.

How long in U. S., if of foreign birth? yrs mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mildred M.*6 DATE OF BIRTH (month, day, and year) *June 21 1904*

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

*23**11**23*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Brick Layer*

(b) General nature of industry, business, or establishment in which employed or employer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *md.*10 NAME OF FATHER *Howard C. Shoemaker*11 BIRTHPLACE OF FATHER (city or town) (State or country) *md.*12 MAIDEN NAME OF MOTHER *Jane Gabriel*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *md.*

14

Informant (Address) *Mildred M. Shoemaker**3249 Chestnut Ave*

15

Filed

19

*C. HARRISON JONES, M. D.*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 14 1928*

17

I HEREBY CERTIFY That I attended deceased from

*May 7 1928 to May 14 1928*that I last saw him alive on *May 14 1928*and that death occurred, on the date stated above, at *5 25 P.* m.

The CAUSE OF DEATH\* was as follows:

*Bronchial Pneumonia*(duration) yrs mos. ds. *7*

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds. *2*18 Where was disease contracted if not at place of death? *yes*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Exam*(Signed) *J. H. Darty* M. D.19 (Address) *Medical Academy*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL

DATE OF BURIAL

*St. Mary's Hospital**5/17 1928*

20 UNDERTAKER

ADDRESS

*Chenoweth Son**3615 Chestnut Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33980

## CERTIFICATE OF DEATH

E 33980

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (City or town)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

## WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds.

How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, state name of (or) WIFE of Mary Troch

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years 61

Months ?

Days 2

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY That I attended deceased from

April 25, 1928, to May 16, 1928,

that I last saw him alive on May 16, 1928,

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH\* was as follows:

Diabetes mellitus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

16, 1928

Address)

1031 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33981

## CERTIFICATE OF DEATH.

E 33981

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital* ST. *9-47* WARD)2-FULL NAME *Mr. Howard Schaeffer*(a) RESIDENCE NO. *3539 Greenmount Ave*  
(Usual place of abode) ST. \_\_\_\_\_ WARD \_\_\_\_\_Length of residence in city or town where death occurred *dis* yrs. \_\_\_\_\_ mos. \_\_\_\_\_How long in U. S., if of foreign birth? *dis* yrs. \_\_\_\_\_ mos. \_\_\_\_\_

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Eva*6 DATE OF BIRTH (month, day, and year) *Oct-12-1892*7 AGE Years *35* Months *7* Days *2* If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. *Confectioner*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *md*10 NAME OF FATHER *James E Schaeffer*11 BIRTHPLACE OF FATHER (city or town) *Balto*  
(State or country) *md*12 MAIDEN NAME OF MOTHER *Mellie Fisher*13 BIRTHPLACE OF MOTHER (city or town) *Balto*  
(State or country) *md*14 Informant *Mr. Jas. Schaeffer*  
(Address) *3539 Greenmount Ave*15 *C. HAMPSON JONES, M. D.*  
*Regist*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-14-28*

17

I HEREBY CERTIFY, That I attended deceased from *5-9*, 19 *28*, to *5-14*, 19 *28*.that I last saw him alive on *5-14*, 19 *28*and that death occurred, on the date stated above, at *2 P. M.*

The CAUSE OF DEATH\* was as follows:

*Tubercular Meningitis*(duration) *about* yrs. \_\_\_\_\_ mos. *14* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis *clinical*Where deceased was buried, cremated, or disposed of *St Agnes Hospital*

(Address) \_\_\_\_\_

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Cathedral Cemetery**5-17-28*

20 UNDERTAKER

*Martin Baker & Sons*

ADDRESS

*North Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

16 1928



E 33982

## HEALTH DEPARTMENT—CITY OF BALTIMORE E 33982

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *South Baltimore General Hospital* REGISTERED NO. *143-001*  
 CITY OF BALTIMORE: (No. *1213* *light* ST. *7-1* *W*) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 2-FULL NAME *Mrs. Rose Muebuis*  
 (a) RESIDENCE NO. *926 N. Duncan* ST., WARD \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *34* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*  
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of *William Muebuis*  
 6 DATE OF BIRTH (month, day, and year) *Nov 1892*  
 7 AGE Years *35* Months *6* Days \_\_\_\_\_ If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At home*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *No Inquest necessary*  
 (c) Name of employer *Dr. M. D. Jones*

9 BIRTHPLACE (city or town) *MD*  
 (State or country)

10 NAME OF FATHER *Joseph Taylor*

11 BIRTHPLACE OF FATHER (city or town) *MD*  
 (State or country)

12 MAIDEN NAME OF MOTHER *Elizabeth Hilgartner*

13 BIRTHPLACE OF MOTHER (city or town) *MD*  
 (State or country)

14 Informant *Thelma M. D. Jones*  
 (Address) *4405 Kathleen Ave*

MAY 15 1928

19

Pm

C. HAMPSON JONES, M. D.  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 15 1928*

17 I HEREBY CERTIFY, That I attended deceased from *Apr 12*, 19 *28*, to *May 15*, 19 *28*, that I last saw him alive on *May 15*, 19 *28*, and that death occurred, on the date stated above, at *2:45* p.m.

The CAUSE OF DEATH\* was as follows:

*Septicemia following incomplete abortion*

(duration) yrs. *1* mos. ds. CONTRIBUTORY (Secondary) *Mic myocarditis & Endocarditis* (duration) yrs. mos. *7* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Apr 12*

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical*

(Signed) *Thelma M. D. Jones* M. D.

15, 1928 (Address) *1213 light 54*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

*London Park* *May 18 1928*

20 UNDERTAKER *Wm. Cook* ADDRESS *500 E. North*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33983

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 9-46 WARD)2-FULL NAME Wilmer Musgrove Dimster(a) RESIDENCE NO. 1611 E. 32nd ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19 19157 AGE Years 13 Months 4 Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Jonas Dimster11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Lily Ballinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James Dimster (Address) 1611 E. 32nd St.15 Filed 16 1928 G. HAMMOND JONES, M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16 192817 I HEREBY CERTIFY, That I attended deceased from 5/5/28, 1928, to 5/16, 1928, that I last saw him live on 5/16/28, 1928, and that death occurred, on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia(duration) — yrs. — mos. 3 ds.CONTRIBUTORY Acute rheumatic fever, acute endocarditis (Secondary) (duration) — yrs. — mos. 23 ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical (Signed) Lewis Eldon Vaynter, M. D., 19 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn

20 UNDERTAKER

Wm. Cook

DATE OF BURIAL

5/19/28

ADDRESS

508 E. North AveCAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-  
TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33984

## CERTIFICATE OF DEATH

E 33984

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Battery Ave. ST. 24-33 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

Emma J. Smith

## (a) RESIDENCE NO.

1126 Battery Ave.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 0 mos. 0 ds. How long in U. S., if foreign 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Widowed6 If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Smith6 DATE OF BIRTH (month, day, and year) April 10/18407 AGE 84 Years 1 Months 5 Days If LESS than 1 day, 0 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa10 NAME OF FATHER Henry Barnes11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa12 MAIDEN NAME OF MOTHER Ann13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14

Informant (Address) Miller, A. J. Jones

15

Filed 10-19-28 19 28

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15/2817 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928 to May 15, 1928 that I last saw him alive on May 14, 1928 and that death occurred, on the date stated above, at 5:20 PM

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation  
& Arterio Sclerosis  
duration 10 yrs.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7/0Was there an autopsy? NoWhat test confirmed diagnosis? Chemically finding(Signed) R. H. Campbell M. D.(Address) 1644 Hancock St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL DATE OF BURIAL

Heaven Hill May 18 1928

20 UNDERTAKER

ADDRESS

William Beck & Co. Baltimore

important. See instructions on back of certificates.

E 33985

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

E 33985

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3329 Beech ave ST. 13-52)

## 2-FULL NAME

Laura E. Shelley

(a) RESIDENCE NO.

3329 Beech ave ST.

(Usual place of abode)

Length of residence in city or town where death occurred

life yrs. mos. ds.

How long in U. S., if of foreign birth? life yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Widow

5a If married, widowed, or divorced

WIFE of

Hugh E. Shelley

6 DATE OF BIRTH (month, day, and year)

Oct 6/1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66.

7

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

Retired

9 BIRTHPLACE (city or town) (State or country)

Balto city Md.

10 NAME OF FATHER

Henry Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Co. Md.

12 MAIDEN NAME OF MOTHER

Rachel Heider

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Mr William Shelley 3329 Beech ave

15

Filed

19

HAROLD JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15/1928

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1928, to May 15, 1928, that I last saw her alive on May 15, 1928, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis  
Chronic Bronchitis  
Emphysema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address) 8429 Chantrelle

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Woodlawn Cem.  
Halter Davis 3307 Pimlico

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

15 15 1928



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33986

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 8-13 Ward)2-FULL NAME Henry Wolff(a) RESIDENCE NO. 1747 E. Preston St St. 8-13 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. 1 mo. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 Color or Race W 5 Single, Married, Widowed, or Divorced, (write the word) Widower

6a If married, widowed, or divorced HUSBAND of Bertha M. Wolff (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12/1885

7 AGE Years 43 Months 4 Days 3 IF LESS than 1 day.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore(b) General nature of industry, business, or establishment in which employed (or employer) Foreman(c) Name of employer Thomas Ship Co.

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Austin Wolff

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Johnanna Witzell

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Barbar. Wolff (Daughter) (Address) 1747 E. Preston St

15 Filed 1928 C. HAMPSON JONES, M. D. Registrar

## CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15/28

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Hemorrhagic Pancreatitis

(Autopsy at Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY Shock (Secondary)

(duration) yrs. mos. ds.

(Signed) [Signature] M. D. (Coroner)5/16/28 (Address) 508 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial May 17 1928

20 UNDERTAKER Henry Sander & Sons Inc ADDRESS 1710 Fleet St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 33987

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33987

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1144 Woodyear* ST. *16-23* WARD)2-FULL NAME *Fred Douglas Martin*(a) RESIDENCE NO. *1144 Woodyear* ST. WARDLength of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *C* 5 Single, Married, Widowed, or Divorced, (write the word) *widowed*5a ~~Married~~, widowed, or divorced HUSBAND of (or) WIFE of *Flora Martin*6 DATE OF BIRTH (month, day, and year) *Sept 5, 1887*7 AGE *40* Years Months *8* Days *9* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Porter.*(b) General nature of industry, business, or establishment in which employed (or employer) *070*(c) Name of employer *Hagler Bros.*9 BIRTHPLACE (city or town) (State or country) *Virginia*10 NAME OF FATHER *James Martin*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Laura Kelly's*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Virginia*14 Informant (Address) *James A. O'Keefe*  
*Accomac Co. Va.*15 Filed *1928* *19* *16* *17* *18* *19* *20* *21* *22* *23* *24* *25* *26* *27* *28* *29* *30* *31* *32* *33* *34* *35* *36* *37* *38* *39* *40* *41* *42* *43* *44* *45* *46* *47* *48* *49* *50* *51* *52* *53* *54* *55* *56* *57* *58* *59* *60* *61* *62* *63* *64* *65* *66* *67* *68* *69* *70* *71* *72* *73* *74* *75* *76* *77* *78* *79* *80* *81* *82* *83* *84* *85* *86* *87* *88* *89* *90* *91* *92* *93* *94* *95* *96* *97* *98* *99* *100* *101* *102* *103* *104* *105* *106* *107* *108* *109* *110* *111* *112* *113* *114* *115* *116* *117* *118* *119* *120* *121* *122* *123* *124* *125* *126* *127* *128* *129* *130* *131* *132* *133* *134* *135* *136* *137* *138* *139* *140* *141* *142* *143* *144* *145* *146* *147* *148* *149* *150* *151* *152* *153* *154* *155* *156* *157* *158* *159* *160* *161* *162* *163* *164* *165* *166* *167* *168* *169* *170* *171* *172* *173* *174* *175* *176* *177* *178* *179* *180* *181* *182* *183* *184* *185* *186* *187* *188* *189* *190* *191* *192* *193* *194* *195* *196* *197* *198* *199* *200* *201* *202* *203* *204* *205* *206* *207* *208* *209* *210* *211* *212* *213* *214* *215* *216* *217* *218* *219* *220* *221* *222* *223* *224* *225* *226* *227* *228* *229* *230* *231* *232* *233* *234* *235* *236* *237* *238* *239* *240* *241* *242* *243* *244* *245* *246* *247* *248* *249* *250* *251* *252* *253* *254* *255* *256* *257* *258* *259* *260* *261* *262* *263* *264* *265* *266* *267* *268* *269* *270* *271* *272* *273* *274* *275* *276* *277* *278* *279* *280* *281* *282* *283* *284* *285* *286* *287* *288* *289* *290* *291* *292* *293* *294* *295* *296* *297* *298* *299* *300* *301* *302* *303* *304* *305* *306* *307* *308* *309* *310* *311* *312* *313* *314* *315* *316* *317* *318* *319* *320* *321* *322* *323* *324* *325* *326* *327* *328* *329* *330* *331* *332* *333* *334* *335* *336* *337* *338* *339* *340* *341* *342* *343* *344* *345* *346* *347* *348* *349* *350* *351* *352* *353* *354* *355* *356* *357* *358* *359* *360* *361* *362* *363* *364* *365* *366* *367* *368* *369* *370* *371* *372* *373* *374* *375* *376* *377* *378* *379* *380* *381* *382* *383* *384* *385* *386* *387* *388* *389* *390* *391* *392* *393* *394* *395* *396* *397* *398* *399* *400* *401* *402* *403* *404* *405* *406* *407* *408* *409* *410* *411* *412* *413* *414* *415* *416* *417* *418* *419* *420* *421* *422* *423* *424* *425* *426* *427* *428* *429* *430* *431* *432* *433* *434* *435* *436* *437* *438* *439* *440* *441* *442* *443* *444* *445* *446* *447* *448* *449* *450* *451* *452* *453* *454* *455* *456* *457* *458* *459* *460* *461* *462* *463* *464* *465* *466* *467* *468* *469* *470* *471* *472* *473* *474* *475* *476* *477* *478* *479* *480* *481* *482* *483* *484* *485* *486* *487* *488* *489* *490* *491* *492* *493* *494* *495* *496* *497* *498* *499* *500* *501* *502* *503* *504* *505* *506* *507* *508* *509* *510* *511* *512* *513* *514* *515* *516* *517* *518* *519* *520* *521* *522* *523* *524* *525* *526* *527* *528* *529* *530* *531* *532* *533* *534* *535* *536* *537* *538* *539* *540* *541* *542* *543* *544* *545* *546* *547* *548* *549* *550* *551* *552* *553* *554* *555* *556* *557* *558* *559* *560* *561* *562* *563* *564* *565* *566* *567* *568* *569* *570* *571* *572* *573* *574* *575* *576* *577* *578* *579* *580* *581* *582* *583* *584* *585* *586* *587* *588* *589* *590* *591* *592* *593* *594* *595* *596* *597* *598* *599* *600* *601* *602* *603* *604* *605* *606* *607* *608* *609* *610* *611* *612* *613* *614* *615* *616* *617* *618* *619* *620* *621* *622* *623* *624* *625* *626* *627* *628* *629* *630* *631* *632* *633* *634* *635* *636* *637* *638* *639* *640* *641* *642* *643* *644* *645* *646* *647* *648* *649* *650* *651* *652* *653* *654* *655* *656* *657* *658* *659* *660* *661* *662* *663* *664* *665* *666* *667* *668* *669* *670* *671* *672* *673* *674* *675* *676* *677* *678* *679* *680* *681* *682* *683* *684* *685* *686* *687* *688* *689* *690* *691* *692* *693* *694* *695* *696* *697* *698* *699* *700* *701* *702* *703* *704* *705* *706* *707* *708* *709* *710* *711* *712* *713* *714* *715* *716* *717* *718* *719* *720* *721* *722* *723* *724* *725* *726* *727* *728* *729* *730* *731* *732* *733* *734* *735* *736* *737* *738* *739* *740* *741* *742* *743* *744* *745* *746* *747* *748* *749* *750* *751* *752* *753* *754* *755* *756* *757* *758* *759* *760* *761* *762* *763* *764* *765* *766* *767* *768* *769* *770* *771* *772* *773* *774* *775* *776* *777* *778* *779* *780* *781* *782* *783* *784* *785* *786* *787* *788* *789* *790* *791* *792* *793* *794* *795* *796* *797* *798* *799* *800* *801* *802* *803* *804* *805* *806* *807* *808* *809* *810* *811* *812* *813* *814* *815* *816* *817* *818* *819* *820* *821* *822* *823* *824* *825* *826* *827* *828* *829* *830* *831* *832* *833* *834* *835* *836* *837* *838* *839* *840* *841* *842* *843* *844* *845* *846* *847* *848* *849* *850* *851* *852* *853* *854* *855* *856* *857* *858* *859* *860* *861* *862* *863* *864* *865* *866* *867* *868* *869* *870* *871* *872* *873* *874* *875* *876* *877* *878* *879* *880* *881* *882* *883* *884* *885* *886* *887* *888* *889* *890* *891* *892* *893* *894* *895* *896* *897* *898* *899* *900* *901* *902* *903* *904* *905* *906* *907* *908* *909* *910* *911* *912* *913* *914* *915* *916* *917* *918* *919* *920* *921* *922* *923* *924* *925* *926* *927* *928* *929* *930* *931* *932* *933* *934* *935* *936* *937* *938* *939* *940* *941* *942* *943* *944* *945* *946* *947* *948* *949* *950* *951* *952* *953* *954* *955* *956* *957* *958* *959* *960* *961* *962* *963* *964* *965* *966* *967* *968* *969* *970* *971* *972* *973* *974* *975* *976* *977* *978* *979* *980* *981* *982* *983* *984* *985* *986* *987* *988* *989* *990* *991* *992* *993* *994* *995* *996* *997* *998* *999* *1000*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 14, 1928*17 I HEREBY CERTIFY, That I attended deceased from *May 4, 1928*, to *May 14, 1928*, that I last saw him alive on *May 14, 1928*, and that death occurred, on the date stated above, at *5:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dilation*CONTRIBUTORY (Secondary) *Lagrippe* (duration) yrs. mos. *4* ds.(duration) yrs. mos. *16* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis *Thymic Examination* (Signed) *Paul Brown*, M. D.(Address) *1837 Penna Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Accomac Co Va**May 17, 1928*

20 UNDERTAKER

ADDRESS

*Thomas E. Nelson**1303*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33988

## CERTIFICATE OF DEATH

E 33988

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 218 Armuty 18-16 St. 18-16 Ward)2-FULL NAME Minnie Jane Washington(a) RESIDENCE NO. 218 Armuty St. 18-16 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. (If non-resident give city or town and State)  
How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race colored 5 Single, Married, Widowed, or Divorced, (write the word) widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wesley Washington6 DATE OF BIRTH (month, day, and year) June 18777 AGE 50 Years 11 Months 57 Days IF LESS than 1 day 0 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic  
(b) General nature of industry, business, or establishment in which employed (or employer) at home  
(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country) Sancaester Co VA10 NAME OF FATHER David Lee11 BIRTHPLACE OF FATHER (City or town)  
(State or country) VA12 MAIDEN NAME OF MOTHER Francis Morris13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) VA14 Informant Irene Washington  
(Address) 218 N. Armuty St.15 Filed G. H. HAMILTON Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/15 192817 I HEREBY CERTIFY, That I attended deceased from 5/11 1928 to 5/15 1928, that I last saw her alive on May 14 1928, and that death occurred, on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy  
(duration) 0 yrs. 0 mos. 0 ds.

## CONTRIBUTORY

(Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

## 18 Where was disease contracted

if not at place of death? ✓Did an operation precede death? 0 Date of 0Was there an autopsy? 0

What test confirmed diagnosis?

(Signed) B. J. Fletcher M. D.  
(Address) 1111 Pa Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

Sancaester VAMay 18 1928

## 20 UNDERTAKER

ADDRESS

Thomas G. Nelson1303  
Princeton St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33989

E 33989

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *1-3* WARD)2-FULL NAME *Steve Senko*(a) RESIDENCE NO. *800 S. Milton Ave.* ST. *57* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)*Male**White**Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec. 11-1927*

7 AGE

Years

Months

Days

If LESS than  
1 day... hrs.  
or... min*5**4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

*None*9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*

10 NAME OF FATHER

*Ignatius Senko*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Poland*

12 MAIDEN NAME OF MOTHER

*Frances Wozniak*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Poland*

14

Informant  
(Address)*Frances Senko  
800 S. Milton St*

15

Filed

19

*HAMMON JONES, M.D.*  
*RPH* Registrar

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 15, 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*May 14, 1928, to May 15, 1928,*  
that I last saw him alive on *May 15, 1928,*  
and that death occurred, on the date stated above, at *8 25 p. m.*

The CAUSE OF DEATH\* was as follows:

*Laryngeal Diphtheria*(duration) yrs. mos. *9* ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. *1* ds.18 Where was disease contracted  
if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*  
(Signed) *Dr. J. P. Levin* M. D.5-16-1928 (Address) *Sydenham Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Holy Rosary May 17 1928*

20 UNDERTAKER

ADDRESS

*John M. Weber 401 S. Chester*Exact statement of OCCU-  
CAUSE OF DEATH in plain terms, so that it may be properly classified.  
TION is very important. See instructions on back of certificates.

16 1928



E 33990

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33990

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 13001

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs

mos.

ds.

How long in U. S. if of foreign birth?

50 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

widow

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-15-1928

17

I HEREBY CERTIFY That I attended deceased from

11-21-1927 to 5-15-1928

that I last saw her alive on 5-15-1928

and that death occurred on the date stated above at 12:15 P. M.

The CAUSE OF DEATH was as follows:

Terminal Bronchopneumonia

(duration)

yrs

mos

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs

mos

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33991

E 33991

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1216 Lorgeant*)

## 2-FULL NAME

(Residence in Baltimore: No. *1216 Lorgeant*)*Octavia A Bussey*

REGISTERED NO C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St *40* yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

*Widow*  
(Write the word.)

## 6-DATE OF BIRTH,

*April 16, 1950*  
(Month) (Day) (Year)

## 7-AGE,

*78 yrs. 1 mos. 4 da.*If LESS than 1 day,  
...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE,  
(State or Country),*Harford Co Md*

## 10-NAME OF FATHER,

*John Houbrocker*11-BIRTHPLACE OF FATHER  
(State or Country),*Unknown*

## 12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER  
(State or Country),*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thos. L. Jones*(Address) *1216 Lorgeant*

## 15-

Filed *16* 1928

C. HANSON JONES, M. D.

191

RR 14

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 16-DATE OF DEATH,

*May 15, 1928*  
(Month) (Day) (Year)17- I HEREBY CERTIFY That I attended deceased from *April 12, 1928* to *May 15, 1928*, that I saw him alive on *May 12, 1928*, and that death occurred, on the date stated above, at *8:00* m. The CAUSE OF DEATH\* was as follows:*Valvular Disease of Heart*(Duration) *1* yrs. *1* mos. *1* da.CONTRIBUTORY  
(Secondary)(Duration) *1* yrs. *1* mos. *1* da.(Signed) *Dr. J. H. Jones**5716* 1928 (Address) *5716 Lorgeant*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*St Ignatius, Sicker* *May 18, 1928*

## 20-UNDERTAKER

## ADDRESS

*Harry H. White* *1531 W. Lomb*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33992

## CERTIFICATE OF DEATH.

90 E 33992

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Don Secours Hospital*)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *Five* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

HAMILSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 15 1928*

17

I HEREBY CERTIFY, That I attended deceased from  
*July 1*, 19*27*, to *May 15*, 19*28*,  
that I last saw her alive on *May 14*, 19*28*,  
and that death occurred, on the date stated above, at *8<sup>15</sup>* A. M.  
The CAUSE OF DEATH\* was as follows:*Myocarditis Chronic  
Spastic Paralysis*(duration) *6* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 17 1928

## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33993

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3026 Wayne ave* *Howard Park* *28-64* WARD)2-FULL NAME *William Ernest Proff*(a) RESIDENCE NO. *3026 Wayne ave*

(Usual place of abode)

Length of residence in city or town where death occurred *69* yrs. *9* mos. *16* ds.

ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 33993

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *white*5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 5, 1858*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Patient Siger*(b) General nature of industry, business, or establishment in which employed (or employer) *Dealer*(c) Name of employer *Self*9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *August Proff*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Donthner*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *John Proff Jr 1208 Calhoun St*

15

Filed

AY 17 1928

19

HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 14* 19*28*

17

I HEREBY CERTIFY, That I attended deceased from *May 9*, 19*28*, to *May 14*, 19*28*, that I last saw him live on *May 14*, 19*28*, and that death occurred, on the date stated above, at *7:50 P. m.*

The CAUSE OF DEATH\* was as follows:

*Academy of Surge*

(duration)

yrs.

mos.

5

ds.

CONTRIBUTORY (Secondary)

(duration)

2 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Autopsy*

(Signed)

*A. C. Smith*

M. D.

Address *4509 Liberty Ave*  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St Pauls Violetteville**5/17/28*

20 UNDERTAKER

ADDRESS

*Mrs. M. B. Brown 2003 Edmondson*



## HEALTH DEPARTMENT-CITY OF BALTIMORE

E 33994

## CERTIFICATE OF DEATH

E 33994

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1323 Hanover* St. *23-31* Ward)2-FULL NAME *Dorothy V. Hildebrand*(a) RESIDENCE NO. *1323 Hanover* St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER *Wm Hildebrand*

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER *Mary Hauer*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

*William Hildebrand*  
*1323 Hanover St*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

*May 10, 1928* to *May 10, 1928*that I last saw him alive on *May 10, 1928*and death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH\* was as follows:

*Branchio Pneumonia*  
*(Primary)*  
duration yrs. mos. ds. *5*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *1*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. H. Campbell* M. D.1928 (Address) *1644 Hanover*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 17 1928

G. HAMMOND JONES, M. D.  
*K.H.H.**Edgar Hill*  
*1323 Hanover*  
*115 E North*

E 33995

## HEALTH DEPARTMENT—CITY OF BALTIMORE

33995

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *30* WARD)2-FULL NAME *Samuel J. Morningstar*(a) RESIDENCE NO. *Ridewood Rd* ST. *5* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

*2*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary Morningstar*6 DATE OF BIRTH (month, day, and year) *1851*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*77*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *"*(c) Name of employer *"*9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *"*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *"*

14

Informant (Address) *Samuel J. Morningstar*  
*Ridewood Rd*

15

Filed

19

Registrar *W. H. H.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 16, 1928*

17

I HEREBY CERTIFY, That I attended deceased from

*May 14, 1928, to May 16, 1928.*that I last saw him alive on *May 16, 1928.*and that death occurred, on the date stated above, at *8:15 A.M.*

The CAUSE OF DEATH\* was as follows:

*Arterio-sclerotic Cardio-vascular disease with hypertension and auricular fibrillation.*(duration) *5* yrs. *10* mos. *10* ds.CONTRIBUTORY *Acute prostatic retention.*

(Secondary)

(duration) *10* yrs. *10* mos. *10* ds.18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis? *Clinical findings*(Signed) *H. V. E. H. H.*, M. D.19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Forest Hill Cms.*DATE OF BURIAL *May 18, 1928*20 UNDERTAKER *John B. B. B.*ADDRESS *John B. B. B.*

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Every item of information should be carefully supplied. Exact AGE should be stated. Exact CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 33996  
PLACE OF DEATH  
County Baltimore

54 ✓ E 33996  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Village or City Hamilton (No. 2710. Evergreen St. 27-42 Ward)

2 FULL NAME Mary Ellen Pocock  
3 months Sunnybrook Cr.

Registration Dist. No. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Oct 27 1855  
(Month) (Day) (Year)

7 AGE 72 yrs. 6 mos. 18 ds. If LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Muse  
(b) General nature of industry business, or establishment in which employed or (employer) Muse

9 BIRTHPLACE (State or country) Maryland.

10 NAME OF FATHER John Pocock

11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Hendricks

13 BIRTHPLACE OF MOTHER (State or country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. E. Pocock  
(Address) Pococks Balto Co.

15 17 1928 192 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 15 1928  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 11 1928 to May 15 1928, that I last saw him alive on May 15 1928, and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH was as follows:  
Diabetes

Contributory Secondary Gangrene  
(Duration) 5 yrs. mos. ds.

(Signed) Geo. J. Jones M. D.  
May 16 1928 (Address) 1834 27 Ave 27

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Glenview

19 PLACE OF BURIAL OR REMOVAL Hammock Mt. DATE OF BURIAL May 18 1928

20 UNDERTAKER John Burns Sons ADDRESS Jordan

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SPR.—8-24-14—M. & T.—2000 Eds.

E 33997

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33997

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1509 N Caroline*)

ST.: *8-17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Edith J Davis*

(Residence in Baltimore: No. *1509 N Caroline*)

St.: yrs. *5* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Female*

4-COLOR OR RACE,

*White*

5-SINGLE,

*Single*  
~~MARRIED,~~  
~~WIDOWED,~~  
~~OR DIVORCED,~~  
(Write the word.)

6-DATE OF BIRTH

*July* *3*, *1854*  
(Month) (Day) (Year)

7-AGE,

*73* yrs. *10* mos. *13* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

*Housewife*

9-BIRTHPLACE,

(State or Country).

*Pittston Pa*

10-NAME OF FATHER,

*David Davis*

11-BIRTHPLACE OF FATHER

(State or Country).

*England*

12-MAIDEN NAME OF MOTHER

*Ann Morris*

13-BIRTHPLACE OF MOTHER

(State or Country).

*England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *E. J. Davis*

(Address) *1509 N Caroline*

15-

Filed... 191...  
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

*May* *16*, *1928*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 5* *1928*, to *May 16* *1928*, that I saw her alive on *May 16* *1928*, and that death occurred, on the date stated above, at *1:15* p.m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(Duration) ... yrs. ... mos. *11* ds.

CONTRIBUTORY (Secondary)

*Arteriosclerosis High B.P.*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *E. J. Davis* M. D.

*May 16*, *1928* (Address) *1509 N Caroline*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

*Pittston Luzerne Co. Pa*

DATE OF BURIAL

*May 18*, *1928*

20-UNDERTAKER

*John B. Spencer*

ADDRESS

*1325 N Cadwell*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

E 33998

## CERTIFICATE OF DEATH.

90 E 33998

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Arguith ST. 10-14 WARD)2-FULL NAME Eleanora P. Boone

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 702 Arguith ST. 10-14 WARD(Usual place of abode)  
Length of residence in city or town where death occurred\* 56 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) July 27, 18727 AGE Years 56 Months 2 Days 18 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer " "9 BIRTHPLACE (city or town) (State or country) Balto Maryland10 NAME OF FATHER William H. Boone11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland12 MAIDEN NAME OF MOTHER Sarah R. Young13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland14 Informant Wm. Armacost (Address) 702 Arguith St.15 Filed 19 HA 1926 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 192817 I HEREBY CERTIFY, That I attended deceased from June, 1927, to May, 1928, that I last saw him alive on May 15, 1928, and that death occurred, on the date stated above, at 12:15 m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. Kelsey, M. D., 19 28 (Address) 1512 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Mount Cem.May 16, 1928

20 UNDER

ADDRESS

John B. Spence 1328 N. CamdenSR

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 33999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161 E 33999

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3212 Taylor an ST. 27-43 WARD)

2-FULL NAME Dorothy Mae Valerik

(a) RESIDENCE NO. 3212 Taylor an ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16, 1928

7 AGE Years Months Days If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER August Volker

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Catherine Mann

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant (Address) August Volker 3212 Taylor an

15 Filed MAY 17 1928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1928

17 I HEREBY CERTIFY, That I attended deceased from

May 16, 1928, to May 16, 1928,

that I last saw her alive on May 16, 1928,

and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? 30

(Signed) D. L. Jones M. D.

(Address) 2701 E. 16

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

UNDERTAKER

J. B. Whippert, 1850 N. Calver

E 34000

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

E 34000

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 12-49 WARD

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

30 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs Leo Mayer

6 DATE OF BIRTH (month, day, and year)

Jan 4 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

65

4

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Australia

10 NAME OF FATHER

Simon Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Bertha Einstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

self

15

Filed

MAY 17 1928

HUTCHINSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10 1928

17

I HEREBY CERTIFY, That I attended deceased from after 1 1928 to May 10 1928.

that I last saw him alive on May 10 1928 and that death occurred, on the date stated above, at 10 25 P.m.

The CAUSE OF DEATH\* was as follows:

Neoplasm sigmoid

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of May 5 '28

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOV.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Baltimore

5-17-1928

Paul Lewis, 1439 E. Balto.



CITY HALL  
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

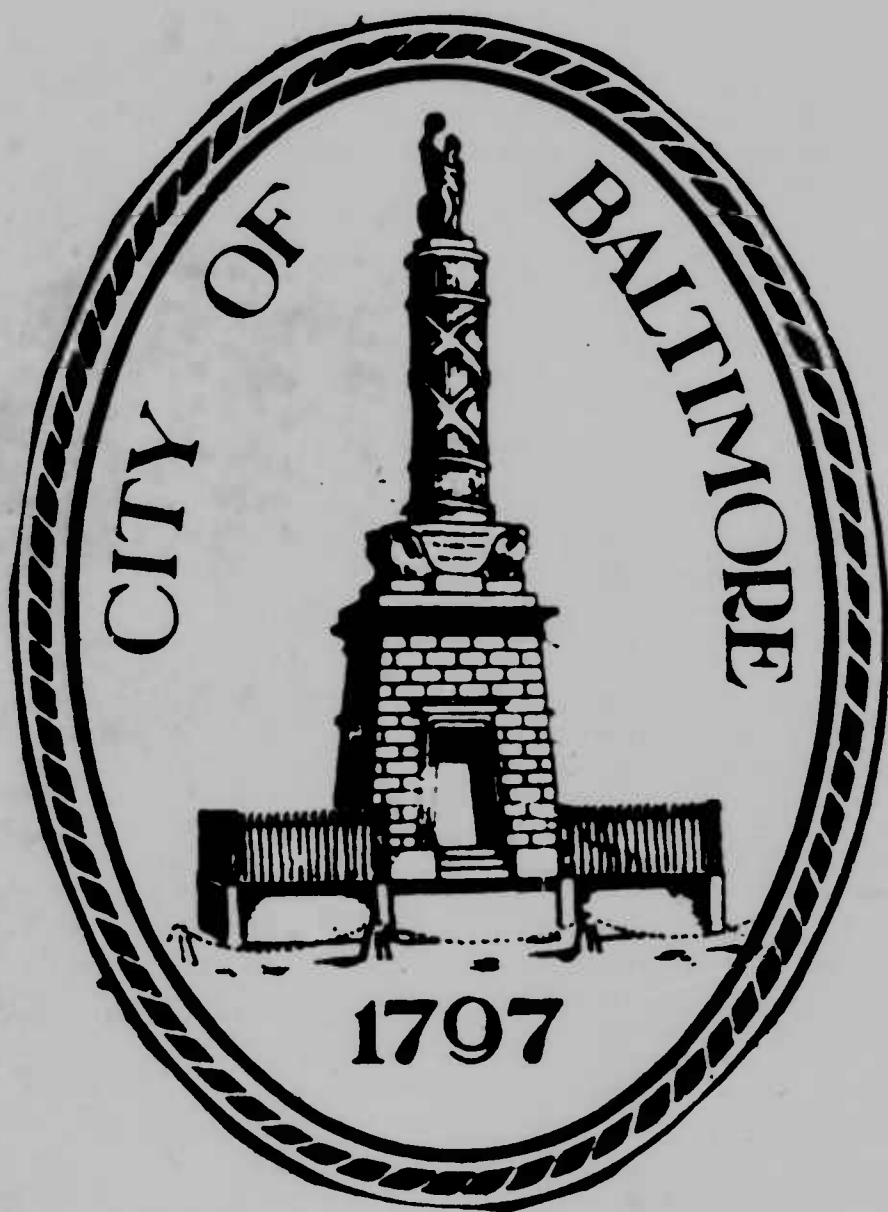
## CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 23<sup>rd</sup> Apr.  
OF 1965 THE MICROPHOTOGRAPHS APPEARING  
#E 30846-  
HEREIN STARTING WITH Feb 23, 1928 AND  
#E 34,000-  
ENDING WITH MAY 17, 1928 ARE AC-  
CULATE AND COMPLETE REPRODUCTIONS OF THE  
RECORDS OF THE DEPARTMENT OF Health  
BUREAU OF Vital Statistics AS DELIVERED  
IN THE REGULAR COURSE OF BUSINESS FOR  
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM  
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU  
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC  
COPY.

CAMERA OPERATOR: D. McFaul





**END OF REEL**